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**Employee Benefit Plan
Plan Document & Summary Plan Description**

 **Primary
PhysicianCare®**

Plan Revision Date: 1/1/11

Plan Effective Date: 1/1/11

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INTRODUCTION

This document is the Summary Plan Description and Master Plan Document for the Averett University Employee Benefit Plan (the “Plan”). The Plan is designed and maintained by Averett University (referred to as “Employer” or “Plan Sponsor”) to provide health care benefits in the event of injury or illness to covered employees and dependents.

Coverage under the Plan for an employee and the employee’s designated dependents will become effective when the employee and such dependents satisfy the waiting period and all the eligibility requirements of the Plan. Covered employees and dependents are referred to as “members.”

The Plan uses a provider network. The network is a group of providers (physicians, hospitals, other health care professionals and facilities) contracted to offer health care services at reduced rates to Plan members. Members will be able to choose at any time from the list of in-network providers, or they may obtain health care from a non-network provider. When a member uses an in-network provider, the Plan will pay a larger portion of the covered medical expenses. As a result of the lower contracted rates and the higher benefit rate paid by the Plan, the member will save on health care expenses. However, the member will always have the option to choose any health care provider.

The members should review this booklet carefully, especially the sections pertaining to Care Management Services and Special Provisions. These sections describe certain steps that must be taken before receiving care in order to receive the maximum benefit available under the Plan. Certain services must be pre-approved in order for the member to receive the maximum benefit. If these services are not pre-approved, benefits will not be paid or will be paid at a lower rate.

Averett University intends to maintain this Plan indefinitely. However, it reserves the right to modify, amend or terminate the Plan at any time. If the Plan, or any benefit under the Plan, is modified, amended or terminated, the rights of covered persons are limited to covered charges incurred before the modification, amendment, or termination. (See “Amending and Terminating the Plan” in the General Information section).

The terms of the Plan will be construed and administered to meet the minimum requirements of all applicable federal laws and to provide beneficiaries legally enforceable rights under ERISA. To the extent a Plan provision is contrary to or fails to address the minimum requirements of an applicable federal law, the Plan shall provide the coverage or benefit necessary to comply with such minimum requirements.

This group health plan believes this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain provisions of the Affordable Care Act that apply to other plans.

Questions regarding which provisions apply and which provisions do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Human Resources. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

PLAN INFORMATION

EMPLOYER ID NUMBER: 54-0129860
PLAN NUMBER: 501
PLAN EFFECTIVE DATE: 1/1/11
PLAN REVISION DATE: 1/1/11

EMPLOYEE GROUPS COVERED IN THIS SUMMARY:

This Summary Plan Description and Master Plan Document applies to all eligible employees of Averett University and its participating subsidiaries.

EMPLOYER/PLAN SPONSOR/PLAN ADMINISTRATOR:

Averett University
420 West Main Street
Danville, VA 24541
434-791-5613

AGENT FOR SERVICE OF LEGAL PROCESS:

The Plan Administrator named above is the agent for service of legal process.

PLAN SUPERVISOR:

Primary PhysicianCare, Inc.
P.O. Box 11088
Charlotte, NC 28220-1088
(704) 523-2758

PLAN YEAR/CALENDAR YEAR:

The financial records of the Plan are kept on a plan year basis. The plan year will begin each **January 1** and end on **December 31**. Deductible and co-insurance information is maintained on a calendar year basis.

TYPE OF ADMINISTRATION:

The Plan Administrator has complete power and discretionary authority to manage and administer the Plan. The Plan Administrator may delegate any assigned administrative duties to one or more designated persons or entities. Processing of initial claims has been delegated to the Plan Supervisor; however, the duties of the Plan Supervisor are merely ministerial in nature and no discretionary authority or responsibility for the Plan has been conferred on or delegated to the Plan Supervisor.

Plan Benefits

The Plan is an employee welfare benefits plan providing medical benefits. The Plan provides benefits only for those covered medical expenses specifically listed in this Summary Plan Description (See the Schedule of Benefits and Covered Medical Expenses sections.)

Funding

The Plan is funded by contributions from the Plan Sponsor and covered employees. The Plan Sponsor determines the level of contributions required, if any, from each participant and reserves the right to evaluate and modify the level of contributions from time to time. The application for enrollment and coverage authorizes the Plan Sponsor to make any required payroll deductions.

HIPAA Privacy Official

Questions about the Plan's privacy policies and procedures and privacy complaints must be directed to:

Averett University
Privacy Official
420 West Main Street
Danville, VA 24541
434-791-5613

SCHEDULE OF BENEFITS

Medical Benefits

When injury or illness causes a member, while covered under this Plan, to incur Covered Medical Expenses, the Plan will determine benefits according to the provisions described in this Summary Plan Description and Master Plan Document. Benefits for each Covered Medical Expense will be calculated as follows:

1. The lesser of the actual, negotiated or the Plan Allowance fee will be determined.
2. The allowable charge will be reduced by any applicable deductible or co-pay and multiplied by the appropriate co-insurance rate, resulting in the benefit payable.
3. The benefit payable will be subject to the maximums shown on this Schedule of Benefits.

Payment

Covered expenses will only be paid if all of the following criteria are met:

1. The service is performed or provided on or after the member effective date.
2. The service is performed or provided prior to termination of coverage.
3. The service provided by a provider within the scope of his or her license.
4. The required Pre-Certification has been obtained (See Care Management Services for a list of services that require Pre-Certification)
5. The Care Management Services requirements have been met.
6. The service is Medically Necessary.
7. The service is not subject to an Exclusion as provided in the Plan.

In – Network Services

The Plan uses in-network providers. “In-network providers” are contracted either directly by the Plan or through a provider network supplementary to the Plan. An “out-of-network provider” is one who has not elected to participate in the Plan. **Averett University** will use the **Gateway Health Alliance Provider Network (GHA)** with additional access through the **Primary PhysicianCare, First Health Network, and Virginia Health Network**. You can access the Provider Directories on-line at the following web addresses to check for participating physicians:

- www.gatewayhealth.com (Virginia providers)
- www.primarypc.com (North Carolina providers)
- www.firsthealth.com (National providers)
- www.vhn.com (for Satellite locations)

Out-of-Area Benefits

Charges for Covered Medical Expenses rendered by a provider where an in-or out-of-network arrangement does not exist will be considered as out-of-area charges.

Calendar Year Deductible

A covered person’s deductible requirement will be met when Covered Medical Expenses paid by that person during each calendar year equal the deductible amount. The covered person is responsible for paying the calendar year deductible. The Plan will not reimburse the covered person for this expense. Co-pays, non-covered charges, hospital per occurrence deductibles, and hospital per admission deductibles do not accrue toward the calendar year deductible.

	In-Network	Out-of-Network
Individual	\$0	\$400
Family	\$0	\$800

Co-Insurance Rate

Co-Insurance rate is the percentage of Covered Medical Expenses payable by the Plan after the deductible requirement is met. The co-insurance rate for each service is listed in the Schedule of Benefits.

Co-Insurance Limit

Once the covered person has satisfied the required calendar year deductible, the Plan will share the payment of covered charges according to the co-insurance rates listed in the Schedule of Benefits.

The Plan pays according to the co-insurance rate until the covered person has paid an amount equal to the co-insurance limit. Once the co-insurance limit has been met, the co-insurance rate will automatically increase to 100% for any additional covered expenses incurred by that same person during the remainder of the calendar year.

If a covered person has health coverage from any other source where coordination of benefits is allowable, including Medicare, Medicaid and TRICARE, the co-insurance limit does not apply.

Member cost for prescription drugs and vision, non-covered charges, negotiated reduction in charges, benefit reduction for failure to comply with pre-certification and Care Management Service Requirements, and charges in excess of Plan Allowance do not accrue toward the co-insurance limit for the year.

	In-Network	Out-of-Network
Individual	\$2,000	\$4,000
Family	\$4,000	\$8,000

Co-pays apply to the co-insurance limit; once the co-insurance limit has been met co-pays will be waived.

PRIMARY CARE SERVICES

Services	In-Network	Out-of-Network (Subject to the Plan Allowance)
1. Charges of primary care physician for an office visit	Payable at 100% after a \$15 co-pay per visit	Payable at 70% after deductible
2. All other charges in a primary care physician's office including surgical procedures	Payable at 80%	Payable at 70% after deductible

WELLNESS SERVICES

Services	In-Network	Out-of-Network (Subject to the Plan Allowance)
1. Routine Physical exams <i>One (1) per year</i>	Payable at 100% after a \$15 co-pay per visit	Payable at 70% after deductible
2. Routine child care (up to age 6)	Payable at 100% after a \$15 co-pay per visit	Payable at 70% after deductible
3. Immunizations (to age 6)	Payable at 100%	Payable at 70% after deductible
4. Immunizations (age 7 and up)	Payable at 100% after a \$15 co-pay per visit	Payable at 70% after deductible
5. Gynecological exams <i>One (1) per year</i>	Payable at 100% after a \$15 co-pay per visit	Payable at 70% after deductible
6. Mammogram <i>One (1) per year</i>	Payable at 80%	Payable at 70% after deductible
7. Prostate, PSA and rectal exams for men <i>One (1) per year</i>	Payable at 80%	Payable at 70% after deductible
8. Contraceptives – All	Payable at 80%	Payable at 70% after deductible

OTHER COVERED SERVICES

Services	In-Network	Out-of-Network (Subject to the Plan Allowance)
1. Charges of a specialist for an office visit	Payable at 100% after a \$30 co-pay	Payable at 70% after deductible
2. All other charges in a specialist office including surgical procedures	Payable at 80%	Payable at 70% after deductible
3. Charges for outpatient diagnostic testing, including but not limited to Magnetic Resonance Imaging (MRI), Cat Scan (CT), x-rays, and independent lab referred by physicians for illnesses not otherwise outlined in the Schedule of Benefits (includes outpatient hospital charges)	Payable at 80%	Payable at 70% after deductible
4. Charges of a hospital (facility) for outpatient treatment	Payable at 80% after a \$100 co-pay	Payable at 70% after deductible
5. Charges of a hospital (facility) for inpatient treatment	Payable at 80% after a \$300 co-pay	Payable at 70% after deductible

Services	In-Network	Out-of-Network (Subject to the Plan Allowance)
6. Charges of a hospital for emergency room care	Payable at 80% after a \$100 co-pay*	Payable at 80%, deductible waived and a \$100 co-pay*
7. Charges of an emergency room physician***	Payable at 100% after a \$30 co-pay	Payable at 100% after a \$30 co-pay
8. Charges of an ambulatory surgery center	Payable at 80% after a \$100 co-pay	Payable at 70% after deductible
9. Charges of an urgent care center	Payable at 80%	Payable at 70% after deductible
10. Charges for maternity services	Payable at 80%. An additional per admission deductible of \$300 will also apply for inpatient stay.	Payable at 70% after deductible
11. Charges incurred which are considered out-of-area	Payable as In-Network	Payable as In-Network (Subject to the Plan Allowance)
12. All other charges to include anesthesiologist, pathologist, radiologist***	Payable at 80%	Payable at 80%, deductible waived**
13. Durable Medical Equipment	Payable at 80%	Payable at 70% after deductible
14. Home Health Care <i>Calendar year maximum 90 visits</i>	Payable at 80%	Payable at 70% after deductible
15. Ambulance Service	Payable at 80%	Payable at 80%, deductible waived**
16. Extended Care Facility, Skilled Nursing Facility, or Rehabilitation Facility <i>Calendar year maximum 100 days per admission</i>	Payable at 80%	Payable at 70% after deductible
17. Hospice Care	Payable at 100%	Payable at 70% after deductible
18. Charges of an office visit for Physical, Speech, and Occupational Therapy	Payable at 80% after a \$30 co-pay	Payable at 70% after deductible
19. Physical, Speech, and Occupational Therapy (Outpatient)	Payable at 80% after a \$30 co-pay	Payable at 70% after deductible
20. Cardiac Rehabilitation (Outpatient)	Payable at 80%	Payable at 70% after deductible

*Co-pay waived if admitted.

**In-network co-insurance limit also applies.

***May be out-of-network even though hospital is in-network

Pre-Certification Penalty

Hospital admissions, outpatient surgeries and other procedures require pre-certification. Pre-certification is the responsibility of the **provider and member**. If pre-certification is not obtained benefits will be **reduced by 50%** (e.g., payable at 80% will be reduced to payable at 30%). Co-insurance payments for services where pre-certification is not obtained do not accrue toward the co-insurance limits. (**See the Care Management Requirements for a list of services requiring pre-certification**).

SPECIAL SERVICES

The following Benefit Limits apply to all physicians, facility and other related charges concerning these services.

Services	In-Network	Out-of-Network (Subject to the Plan Allowance)
Vertebral Manipulation/Outpatient Skeletal Adjustment <i>Calendar year maximum \$500</i>	Payable at 100% after a \$30 co-pay	Payable at 70% after deductible
Pain Therapy / Pain Management	Payable at 80%	Payable at 70% after deductible
Sleep Studies	Payable at 80%	Payable at 70% after deductible
Temporomandibular Joint Dysfunction (TMJ)	Payable at 80%	Payable at 70% after deductible
Private Duty Nursing <i>Calendar year maximum \$500</i>	Payable at 80%	Payable at 70% after deductible
Early Intervention Services <i>Calendar year maximum \$5,000</i>	Payable Where Performed	Payable at 70% after deductible
Surgical Removal of Impacted teeth	Payable at 80%	Payable at 70% after deductible
Allergy Injections	Payable at 80%	Payable at 70% after deductible

This Schedule of Benefits may be revised as more information is made available regarding Healthcare Reform.

PRESCRIPTION DRUG BENEFITS

The Plan includes a prescription drug benefit program, which uses an ID card and a network of participating pharmacies provided by Express Scripts, Inc. Participating pharmacies will accept the required co-payment and file the claim directly. **Claims for expenses incurred at non-participating pharmacies and claims for prescriptions purchased without a drug card will not be covered by the Plan for members who have a valid drug card.**

The Plan includes a mail order prescription drug benefit program administered by Express Scripts, Inc. Refer to the member packet for complete instructions on how to use this program or call ExpressScripts Customer service at 1-800-889-0350.

Express Scripts also offers online tools to manage prescription needs. To get detailed information via the web and learn about the Express Scripts programs and services, visit www.express-scripts.com.

The prescription co-payment rate varies depending on whether the prescription drug is classified as generic, formulary brand or non-formulary brand, as follows:

Prescription Drug Card	
Generic	Member pays \$10 co-pay; <i>maximum 34 day supply</i>
Formulary Brand	Member pays \$20 co-pay; <i>maximum 34 day supply</i>
Non-Formulary Brand	Member pays minimum \$35 or 20% whichever is greater with a \$200 maximum; <i>maximum 34 day supply</i>

Prescription Drug Mail Service	
Generic	Member pays \$10 co-pay; <i>maximum 90 day supply</i>
Formulary Brand	Member pays \$40 co-pay; <i>maximum 90 day supply</i>
Non-Formulary Brand	Member pays minimum \$105 or 20% whichever is greater with a \$400 maximum; <i>maximum 90 day supply</i>

Covered Benefits:

- Federal legend drugs
- Syringes and needles used only to inject insulin
- Insulin
- Oral and injectable contraceptives
- Injectables, subject to pre-certification

Exclusions:

- Appetite Suppressants
- Experimental or Investigational drugs, including compounded medications for non-FDA approved use
- Fertility medications
- Ostomy supplies (covered through the medical plan)
- Retin-A, which may be covered with a letter of medical necessity
- Over-the-counter medications and equivalents
- Vitamins, except prenatal
- Rogaine
- Smoking cessation products
- Therapeutic devices or appliances, support garments, and other non-medical substances

Injectable Drug Program for Chronic Diseases

CuraScript delivers high cost injectable drugs as well as certain oral medications used in the treatment of certain chronic diseases. This drug program is mandatory. The initial prescription requires pre-certification and must be filled at a pharmacy. All re-fills for these medications must be made through the program. After the first fill, members will also receive a letter with instructions about getting their next refill through CuraScript. For more information call CuraScript Customer Service at 1-800-278-0980.

Liberty Medical Supply (Diabetic Pharmacy)

Special coverage for insulin and diabetic supplies obtained from Liberty Medical Supply for members enrolled in the disease management program include:

1. Diabetic supplies ordered from Liberty Medical Supply are covered at 100% with no co-payment. Supplies include blood glucose monitors, lancet devices, blood glucose strips, urine test strips, control solution, blood glucose monitor batteries, alcohol preps, lancets, syringes and insulin pumps and supplies;
2. A 90-day supply of insulin for a maximum of two generic co-payments;
3. Insulin Pumps are covered at 80%, deductible waived.

COVERED MEDICAL EXPENSES

The following expenses are covered by the Plan provided they are incurred for such care, services and supplies as prescribed by an attending physician while the person is covered under this Plan:

1. Charges for medically necessary **abortions** where the life of the mother is endangered if the pregnancy were to be carried to term or in the case of rape or incest.
2. Charges for medically necessary professional **ambulance service** to or from a hospital, or charges by regularly scheduled airline, railroad or air ambulance to the nearest hospital qualified to give the required treatment.
3. Charges for an **ambulatory surgery center**.
4. Charges by a physician or anesthesiologist for **anesthesia** and its administration, provided, however, that CRNA charges billed by a physician *in addition to* an anesthesiologist are not covered medical expenses.
5. When an **assistant surgeon** is required to render technical assistance during an operation, the covered expense for such services shall be limited to 20% of the approved charge for the primary surgeon.
6. Charges for **blood or blood plasma** and its administration, excluding any charges for blood or blood plasma which has been replaced by a donor.
7. Charges for the initial purchase of an external **breast prosthesis** or post mastectomy bra (up to two per year), prescribed in connection with a mastectomy for which the person is receiving benefits under the Plan (however, replacement of the initial breast prosthesis is not covered).
8. Charges for the **circumcision** of a newborn.
9. Charges for **dental care** or treatment performed by a dentist or physician for the following:
 - a. Removal of malignant tumors and cysts.
 - b. Treatment of injury to sound natural teeth incurred as a result of a traumatic injury (other than an injury as a result of eating or chewing), including fixed bridgework and full or partial dentures and crowns, and rendered within twelve (12) months of the traumatic injury.
 - c. Treatment for osteomyelitis as confirmed through pathology.
 - d. Surgical removal of fully impacted wisdom teeth.
10. Charges for **diabetic supplies** to include insulin, syringes with or without needles, needles, alcohol swabs, blood glucose test strips, ketone test strips and tablets, lancets, and devices.
11. Charges for rental of **durable medical equipment** at home, including but not limited to mechanical equipment for the treatment of respiratory paralysis, wheelchairs, and hospital beds; however if the purchase price would be less than the rental cost for long-term usage, the Plan will pay for the purchase of such equipment upon approval from the Plan Supervisor, but not for any repair.
12. Medically necessary patient **education programs** for diabetic and ostomy care.
13. Charges by a **home health** care agency.
14. Charges for **Hospice care**.
15. **Hospital room and board** charges, up to a daily maximum of the prevailing semi-private room rate.
16. Charges for the **initial placement of artificial limbs or eyes**.
17. Hospital charges for **intensive care**, cardiac care or other similar necessary accommodations.
18. Charges for **medically** necessary supplies such as **casts, splints or surgical dressings, trusses, braces (except dental) or crutches**.
19. Charges for medical care or treatment of **mental health disorders (including ADD and ADHD)**.
20. **Miscellaneous hospital** charges (other than room and board) **required for medical or surgical** care or treatment.
21. Hospital charges for routine **newborn nursery care** and for the initial examination by a pediatrician at birth to determine the health of the infant.
22. Charges for medically necessary **nursing care** rendered by a registered nurse (R.N.) or, if none is available as certified by the attending physician, for services rendered by a Licensed Practical Nurse (L.P.N.), but only for nursing duties excluding custodial care and care by members of immediate family.

23. Charges for approved **off-label** anticancer chemotherapy drug indications supported in the American Hospital Formulary Service-Drug Information or in the US Pharmacopoeia-Drug Information compendia.
24. Charges for an **organ transplant incurred by** recipient and the organ donor if the recipient is covered under this Plan (See Organ Transplant Program for details).
25. Charges for **orthoptic** training (eye muscle exercises). Training by an optometrist does not have to be prescribed by a physician. Training by an orthoptic technician must be prescribed by a physician.
26. Charges for **oxygen** and rental of equipment for its administration.
27. Charges for **pain therapy** including, but not limited to, pain clinics and/or labs, epidural steroid injections for the treatment of pain, and all testing and therapies related to the treatment of pain or pain management.
28. Charges for **physical therapy and occupational therapy**, when services are provided by licensed therapists.
29. Charges by a **physician** for medical care and treatment.
30. **Charges** incurred by the covered female employee or spouse due to **pregnancy, childbirth and related conditions** on the same basis as for illness (see Schedule of Benefits).
31. Charges for **prescription drugs** (including insulin) that are (i) ordered for the patient in writing by a physician and (ii) dispensed by a licensed pharmacist or a physician.
32. Charges for **rehabilitative care**, but only for necessary medical care (as prescribed by a physician) which is rendered in a rehabilitation facility or hospital, excluding custodial care or occupational training.
33. Charges for **routine physical examinations**.
34. Charges for treatment received in a **skilled nursing facility or extended care facility**.
35. Charges for sleep studies and treatment include diagnosis, testing, surgery and all charges associated with **sleeping disorders**.
36. Charges for **speech therapy** by a qualified speech therapist required because of an injury or illness other than psychosocial speech delay, behavior problems, attention disorder, conceptual disorder, or mental retardation. If therapy is required because of a congenital abnormality, the person must have had corrective surgery before therapy.
37. Charges for **sterilization** procedures, but not for the reversal of sterilization procedures.
38. Charges for medical care or treatment of **substance use disorders**.
39. Charges made by a physician for **surgical procedures** performed on an inpatient or outpatient basis. In the case of multiple surgical procedures performed through the same incision or separate incisions during the same operative session, the eligible expense for the surgeon will be the Plan Allowance charge or the contractual rate with the provider for the primary procedure, and 50% of the Plan Allowance charge or the contractual rate with the provider for the secondary procedure, and 50% of the Plan Allowance charge or the contractual rate with the provider for the third procedure.
40. Charges for outpatient **skeletal adjustment, adjunctive therapy, vertebral manipulation** and services for the care or treatment of dislocations or subluxations of the vertebrae.
41. Charges for **Temporomandibular Joint Dysfunction**, not to include: orthodontics, crowns, inlays or any appliance that is attached to or rests on the teeth.
42. Charges for **well baby care** services.
43. Charges for one **wig** per lifetime as a result of chemotherapy or radiation treatment.
44. Charges for diagnostic **x-ray or laboratory** examinations and their interpretation.

SPECIAL PROVISIONS

DENTAL SERVICES / ORTHODONTICS / ORAL SURGERY

Expenses for dental services and oral surgery are Covered Medical Expenses only if they are for the prompt repair of natural teeth, bone, or other body tissue needed as a result of a traumatic injury or malignancy. Treatment for cleft lip or cleft palate is covered as any other major medical expense.

EARLY INTERVENTION SERVICES

Early Intervention Services means Medically Necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for Dependents up to age three (3) who are certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services under Part H of the Individuals with Disabilities Education Act. Medically Necessary Early Intervention Services for the population certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services shall mean those services designed to help a covered person attain or retain the capability to function age-appropriately within his/her environment, and shall include services that enhance functional ability without effecting a cure. Coverage is limited to a benefit of \$5,000 per Covered Person per calendar year. The cost of Early Intervention Services shall not be applied to any lifetime maximum benefit under this Plan.

EDUCATION BENEFITS

Charges for Educational Benefits will be covered as explained in the Schedule of Benefits with the following limitations:

1. Diabetic Education, to a lifetime maximum of 10 sessions and \$750.00;
2. Congestive Heart Failure Education, to a lifetime maximum of 5 sessions and \$250.00;
3. Asthma Education, to a lifetime maximum of 5 sessions and \$250.00;
4. Lactation and Well Baby Education, to a maximum of 6 sessions and \$75.00.

EXTENDED CARE, REHABILITATION AND SKILLED NURSING FACILITIES

Charges for services and supplies from qualified extended care, rehabilitation and skilled nursing facilities are Covered Medical Expenses. Services are furnished to a covered person while confined to convalesce from an illness or injury and must occur during a convalescent period. The convalescent period is defined as the first day a covered person is admitted to a facility, if all of the following requirements are met:

1. The person was previously admitted to a hospital for at least three (3) days of inpatient treatment for an illness or injury.
2. The person is admitted to the extended care or rehabilitation facility within thirty (30) days after discharge from the hospital.
3. The person is admitted to the extended care or rehabilitation facility for services needed to convalesce from the condition that caused the hospital stay.

These covered services include skilled nursing and physical restorative care. Covered extended care or rehabilitation facility expenses do not include treatment for substance use disorder, chronic brain syndrome, alcoholism, senility, mental retardation or any other mental disorder.

Pre-certification and Utilization Review are required.

HOME HEALTH CARE

Covered Home Health Care Expenses include:

1. Part-time or intermittent care by an R.N., or by an L.P.N. if an R.N. is not available.
2. Part-time or intermittent home health services including private duty nursing provided by a licensed nurse.
3. Physical, occupation and speech therapy.
4. Medical supplies, medications or lab services ordered by a physician, which require nursing administration.

Pre-certification and Utilization Review are required.

HOSPICE CARE

Hospice care with an approved Hospice Care Program, whether inpatient or outpatient, is a covered benefit. An approved “Hospice Care Program” is a written plan of the care to be provided for the palliation and management of a person’s terminal illness developed by or under the supervision of the attending physician. “Palliative care” is a course of treatment that is primarily directed at lessening or controlling pain while maximizing comfort and does not attempt to cure the person’s terminal illness.

Pre-certification and Utilization Review are required.

HOSPITAL CARE

Intensive care charges in a hospital are Covered Medical Expenses. Private room charges are not Covered Medical Expenses be covered unless certified as medically necessary by the attending physician and pre-certified by Primary PhysicianCare, Inc.

Pre-certification and Utilization Review are required.

MASTECTOMY-BREAST RECONSTRUCTION

Any covered person who is receiving benefits under the Plan in connection with a mastectomy and elects breast reconstruction shall be eligible for coverage of the following, to be provided in a manner determined in consultation with the attending physician and the patient:

1. Reconstruction of the breast on which the mastectomy was performed;
2. Surgical reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications of mastectomy, including lymphedemas.

All of the benefits outlined above are subject to the Plan’s deductibles, co-pay, co-insurance, the Plan Allowance limitations and Care Management Services requirements. For more information, please contact the Plan Supervisor.

Pre-certification and Utilization Review are required.

MATERNITY HOSPITALIZATIONS

Under federal law, the Plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a Cesarean section, or require that a provider obtain authorization from a plan for prescribing a length of stay not in excess of the above period. However, federal law does not prohibit the attending physician, after consultation with the mother, from discharging the mother or newborn before these periods have expired.

MENTAL HEALTH

Charges for treatment of mental health disorders (see Definitions) are Covered Medical Expenses. Charges for treatment of behavioral or learning disabilities are not covered. Prescription drugs used for these conditions are covered as any other prescription drugs, whether prescribed by a psychiatrist or medical doctor.

Pre-certification and Utilization Review are required for inpatient.

NEWBORN CARE

Routine newborn care includes hospital charges for room and board, services, supplies, and professional fees during the initial hospital confinement for in-hospital visits but only while the mother or infant is confined for delivery or post-delivery complications. Also included are charges for circumcision. (See Maternity Hospitalizations). (See Eligibility Requirements.)

ORGAN TRANSPLANTATION

See “Organ Transplant Program” in the **CARE MANAGEMENT SERVICES** section.

Pre-certification and Utilization Review are required.

OUTPATIENT DIALYSIS

Charges for professional fees and services, supplies, medications, labs, and facility fees related to outpatient dialysis are covered expenses. These services include but are not limited to Hemodialysis, Home Hemodialysis, Peritoneal dialysis and Hemofiltration. From the initial outpatient dialysis treatment, regardless of the member's enrollment date with this plan, through the next 42 outpatient treatments, the plan will pay in accordance with the major medical benefits contained in this plan. Benefits will be paid at the in-network level.

For subsequent treatment, the plan allowable for dialysis will be limited to 140% of current year Medicare. The plan will pay 100% of the allowed amount for 30 consecutive months of dialysis or until the plan is secondary to other coverage. Thereafter, standard coordination of benefits will apply.

All members are also eligible to have their Medicare Part B premiums paid for by the plan as long as they continue to be covered under the plan.

Pre-certification and Utilization Review are required.

PHYSICAL, SPEECH AND OCCUPATIONAL THERAPY

Charges of a doctor or facility for physical, speech and occupational therapy that are covered expenses may be limited. The limitation applies for treatment received while the patient is not confined to the hospital as a bed patient (outpatient services). The limitation for treatment applies to the number of days that treatment may be received from the initial date of the accident, injury, or illness. A new period may begin 180 days after the last date of treatment for a given injury or illness. Speech therapy is not covered for psychosocial speech delay, behavior problems, attention disorder, conceptual disorder, or mental retardation.

ROOM AND BOARD CHARGES

Charges by an institution for room and board and other necessary services and supplies must be regularly made at a daily or weekly rate. The semi-private rate is the charge that an institution applies to the beds in a semi-private room with two (2) or more beds. If a facility has private rooms only, it will be paid the same as the semi-private room charge.

SKELETAL ADJUSTMENT

Charges for the treatment of the skeletal system performed by external manipulation including, but not limited to, vertebral manipulation and associated adjunctive therapy are Covered Medical Expenses when medically necessary and when performed by physical therapists, chiropractors, osteopaths, and/or physicians.

SPEECH THERAPY

See Physical, Speech and Occupational Therapy.

SUBSTANCE USE DISORDERS

Charges for the treatment of substance use disorders are Covered Medical Expenses if all of the following requirements are met:

1. The treatment must be prescribed and supervised by a physician.
2. The treatment must have a follow-up therapy program directed by a physician on at least a monthly basis or include meetings at least twice a month with approved organizations devoted to the treatment of substance use disorders such as Alcoholics Anonymous or Narcotics Anonymous.

If a person is confined as an inpatient in a hospital, the covered charges include treatment of the medical complications of substance abuse/substance use. No room and board charges in excess of the semi-private room rate are covered.

If a person is confined as an inpatient in a non-hospital treatment facility, the covered charges include room and board charges equal to the semiprivate room rate. Charges are covered only for facilities that

are recognized by the Joint Commission on Accreditation of Hospitals and licensed by the state. No room and board charges in excess of the semi-private room rate are covered.

Pre-certification and Utilization Review are required for inpatient treatment.

VERTEBRAL MANIPULATION

See Skeletal Adjustment.

WEEKEND HOSPITAL ADMISSION

If a covered person is admitted to a hospital as an inpatient on Friday after 5:00pm, Saturday, or Sunday, no benefits will be paid for charges incurred on those days unless any of the following applies:

1. The confinement was for the birth of a child.
2. Surgery is scheduled within twenty-four (24) hours following admission to the hospital and was pre-certified.
3. The confinement was a medical emergency.

If a hospital confinement is disallowed because of the above, the disallowed amount will **NOT** accrue toward the hospital deductible or co-insurance limits.

EXCLUSIONS

No benefits shall be payable under this Plan for the following:

1. Charges for services performed more than twelve (**12**) **months prior** to receipt of the corresponding claim by the Plan Supervisor.
2. Charges for **abortions**, unless
 - a. It is medically determined that the life or well being of the mother would be threatened by carrying the child to term.
 - b. The pregnancy is the product of rape or incest.
 - c. The fetus has a severe birth defect.
3. Charges resulting from an **accidental injury or illness arising** out of, in connection with, or in the course of working for wages or profit (past or present).
4. Illness or injury resulting from **acts of war**, insurrections, or atomic explosions.
5. Charges for **acupuncture, biofeedback or hypnosis**.
6. Charges for treatment of any injury or illness resulting from: a commission of or an attempt to commit an **assault or felony**. Charges resulting from these activities are excluded whether the covered person was sane, insane, or under the influence of drugs at the time of the activity. This exclusion does not apply if the injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
7. Charges for treatment of an injury resulting from a motor vehicle accident in which a covered person has a **blood alcohol concentration** equal to or in excess of the level established by the laws of the state in which the accident occurred for driving while impaired or where the covered person has pled guilty or was convicted for violating those laws pertaining to driving while impaired or intoxicated for that state. Charges resulting from these activities are excluded whether the covered person was sane, insane, or under the influence of drugs at the time of the activity. This exclusion does not apply if the injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
8. Charges for **attempted suicide or intentionally self-inflicted injury**, while sane or insane, or an injury resulting from an act of aggression or battery initiated by the covered person. This exclusion does not apply if the injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
9. Expenses incurred **before coverage begins or after coverage ends**.
10. Charges for **behavioral disorders or learning disabilities**.
11. Replacement **braces for the leg, arm, back, neck**.
12. **Artificial arms or legs**, unless there is sufficient change in the covered person's physical condition to make the original device no longer functional.
13. **Charges in excess** of the Plan Allowance charges, where a contractual arrangement with the provider does not exist, including but not limited to physicians, hospitals, facilities, and providers of medical equipment and supplies.
14. **Cosmetic**, elective, plastic, reconstructive, or restorative surgery, except following illness or injury as specifically provided for in this Plan, including, but not limited to, rhinoplasty, abdominoplasty, lipectomy, liposuction, breast augmentation, face lifts, and complications arising from such services.
15. Charges for admissions or portions thereof for **custodial care or long-term care**, including:
 - a. Rest Care.
 - b. Long term acute or chronic psychiatric care.
 - c. Care to assist a Member in the performance of activities of daily living (including, but not limited to: walking, movement, bathing, dressing, feeding, toileting, continence, eating, food preparation, and taking medication).
 - d. Care in a sanitarium.
 - e. Custodial or long-term care.
 - f. Psychiatric or substance use disorder residential treatment, including: Residential Treatment Centers, Therapeutic schools, Wilderness/Boot camps, Therapeutic Boarding Homes, Half-way Houses, and Therapeutic Group Homes.
16. Treatment of injuries that result from participation in the following **dangerous leisure activities**:
 - a. Pilot or co-pilot of an ultralight.

- b. Organized racing **including, but not limited to**, competition in an automobile, motorcycle, balloon, hydroplane, powerboat, or ATV.
 - c. Participation in soaring, parachuting, skydiving, or bungee jumping.
 - d. Professional sports of any type.
- This exclusion does not apply if the injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
17. The **difference between the charge** for a service, procedure, or substance and the charge for a service, procedure, or substance that is known to be less expensive and would achieve the same or similar results with no additional medical risk.
 18. All **exercise programs** or exercise equipment for treatment of any condition, outside of prescribed rehabilitation program.
 19. **Any Experimental or Investigational treatment**, procedure, facility, equipment, service, device, substance, or drug (see the Definitions section).
 20. Charges for **genetic counseling and testing** that are not needed for diagnosis or treatment of genetic abnormalities.
 21. Any expenses for treatment, services, supplies, and facilities provided by or in a hospital owned or operated by any **government or agency thereof** where such care is provided at government expense under a plan or program established pursuant to the laws or regulations of any government or under a plan or program under which any government participates other than as an employer. The term “any government” includes the federal, veteran, state, provincial, municipal, or local government or, any political subdivision thereof, of the United States or of any other country. The Plan shall not exclude benefits for a covered person who received billable medical care at any of the above facilities.
 22. **Hearing aids**, devices, and implants used to improve hearing.
 23. Any expense or charge for the diagnosis or treatment of **infertility** in men or women including:
 - a. Fertility studies or tests.
 - b. Reversals of surgical sterilization including reconstruction of vasectomy or reconstruction of tubal ligation.
 - c. Direct attempts to cause pregnancy by hormone therapy, artificial insemination, in vitro fertilization and embryo transfer.
 - d. Supervision of pregnancy by infertility specialists who do not practice obstetrics.
 24. **Marital counseling, recreational, educational, or social therapy or training services** or any form of non-medical self care or self help training and any related diagnostic testing, except for medically necessary patient education programs for diabetic and ostomy care.
 25. Services and supplies that are **not Medically Necessary** except for covered wellness benefits.
 26. Conditions arising out of or as a result of **military service**.
 27. Medical services or supplies for which **no charge** was made or for which no payment would be required if the covered individual was not covered under this Plan.
 28. Charges for services and supplies that are **non-covered expenses**.
 29. **Nutritional supplements**, special foods, or vitamins not prescribed by a physician.
 30. Any treatment of **obesity** or **weight reduction**, whether surgical or medical.
 31. Professional services performed by the covered person or a person who **ordinarily resides in the covered person’s home** or is related to the covered person as a spouse, parent, child, brother, or sister, whether the relationship is by blood or exists in law.
 32. Any artificial, mechanical or cross-species **organ or tissue transplant**.
 33. Charges for treatment **outside of the United States**. This exclusion does not apply to a resident of the United States traveling for business or pleasure that requires emergency medical treatment.
 34. **Personal comfort items** such as television, telephones, extra food trays, etc.
 35. Charges for **pre-existing conditions** for covered persons over the age of 19.
 36. Charges for **pregnancy** including delivery and complications **for covered dependents** other than the spouse of the covered employee.
 37. Charges incurred as a **result of complications** arising from a service or procedure that is not a Covered Medical Expense.
 38. Services or supplies related to **sexual dysfunctions** or inadequacies including penile prosthesis, implants and all procedures and equipment developed for male impotency.
 39. Charges for **shock wave therapy** for orthopedic procedures, including but not limited to the treatment of Plantar Fasciitis, Patellar Tendonitis, Shoulder Tendonitis and Medial Epicondylitis.

40. Charges for **telephone** consultations, missed appointments, or fees added for **filling out a claim form**.
41. Charges related to hospital pre-certification, concurrent review, utilization **review, quality assurance, or case management**.
42. Expenses incurred after **termination of coverage** under this Plan.
43. Charges for routine examinations, periodic physical examinations, childhood checkups, examinations or services required or requested by any **third party**, including, but not limited to, such services for employment, license, insurance, school, or recreational purposes. This includes hospital charges to the extent they are allocable to scholastic **education, vocational training**, or for confinements resulting from a local or state mandate (court ordered).
44. Charges for which a **third party is liable** (See “Third Party Recovery” section) or charges for which the covered person is **not legally required to pay**.
45. Care, services, or treatment for **transsexualism, gender dysphoria or sexual reassignment** or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
46. **Travel**, except for covered ambulance charges.
47. Charges incurred for any operation or **treatment for realignment of teeth or jaw or any other dental services not specifically provided for under Covered Medical Expenses**. Charges not covered include, but are not limited to: **oral care** or supplies for treatment of nerves connected to teeth, charges for treatment of atrophy of the lower jaw, occlusion, maxillofacial surgery, Temporomandibular Joint dysfunction, retrognathia, and related hospital and facility charges. The above charges are excluded unless otherwise provided in the Schedule of Benefits, or provided under DENTAL CARE/ORTHODONTICS/ORAL SURGERY (See the Special Provisions section). This exclusion shall not be construed to deny otherwise eligible expenses for the treatment of the teeth or jaws when such treatment is necessitated by traumatic injury that occurs within one year prior to the treatment.
48. The following care, **treatment or supplies for the feet**: orthopedic shoes, orthopedic prescription devices to be attached to or placed in shoes, treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions except open cutting operations, and treatment of corns, calluses or toenails unless needed in treatment of a metabolic or peripheral-vascular disease.
49. **Vision care** including but not limited to eyeglasses, contact lenses, refractions, radial keratotomy, LASIK surgery and any surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error, unless covered by a vision benefit in the Plan.
50. **Weekend admissions** as described in the DEFINITIONS section.
51. Charges resulting from illness or injury covered by the **Worker’s Compensation Act** or similar law (See Workers Compensation Section).

WORKERS' COMPENSATION

This policy does not provide benefits for diagnosis, treatment or other service for any injury or illness that is sustained by a member that arises out of, in connection with, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required or is otherwise available for the member. Benefits will not be provided under this Plan if coverage under the Workers' Compensation Act or similar law would have been available to the member but the member elects exemption from available Workers' Compensation coverage; waives entitlement to Workers' Compensation benefits for which he/she is eligible; failed to timely file a claim for Workers' Compensation benefits; or, the member sought treatment for the injury or illness from a provider which is not authorized by the member's employer.

If the Plan pays benefits for an injury or illness and the Plan determines the member also received Workers' Compensation benefits by means of a settlement, judgment, or other payment for the same injury or illness, member shall reimburse the Plan in full all benefits paid by the Plan relating to the injury or illness.

The Plan's right of recovery will be applied even if: the Workers' Compensation benefits are in dispute or are made by means of a compromised, doubtful and disputed, clincher or other settlement; no final determination is made that the injury or illness was sustained in the course of or resulted from the member's employment; the amount of Workers' Compensation benefits due to medical or health care is not agreed upon or defined by the member or the Workers' Compensation carrier; or, the medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

PRE-EXISTING CONDITIONS

A Pre-Existing Condition is a condition for which medical advice, diagnosis, care or treatment was recommended or received within six (6) months preceding the person's enrollment date for this Plan. Genetic information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests, or prescribed medications. In order for a condition to be determined as pre-existing, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a physician.

Covered charges incurred for Pre-Existing Conditions are not payable unless incurred twelve (12) consecutive months after the person's enrollment date in this Plan, or eighteen (18) months if the person is a late enrollee. The length of the Pre-Existing Condition exclusion may be reduced or eliminated if the person has proof of creditable coverage from another health plan. "Creditable coverage" is a period of coverage under a prior health plan without a break in coverage of sixty-three (63) days or more.

1. An eligible person may request a certificate of creditable coverage from his or her prior plan. The Employer will assist any eligible person in obtaining a certificate of creditable coverage from the prior plan.
2. If, after a certificate of creditable coverage has been obtained, there is still a Pre-Existing Condition exclusion imposed on an individual, that individual will be so notified.

Enrollment date is the first day of coverage by this Plan, or, if the Plan has a waiting period, the first day of the waiting period. If a member does not immediately enroll, the enrollment date for that member will be considered the first day of coverage under the Plan. (See Timely or Late Enrollee)

The Pre-Existing Condition limitation does not apply to:

1. Pregnancy.
2. Any covered person who is under the age of 19.

ELIGIBILITY

ELIGIBILITY REQUIREMENTS

Requirements for Employee Coverage: A person is eligible for employee coverage as of the date that all of the following requirements are met:

1. The person is a full-time employee of the Employer. An employee is full-time if regularly scheduled to work at least **thirty-seven and a half (37.5) hours** per week and on the regular payroll of the Employer.
2. The person is in a class eligible for coverage under the Plan.
3. The person has completed the waiting period as an active employee. A “waiting period” is the time between the first day of employment and the first day of the month following the date of hire. Absences due to health reasons will be disregarded in determining whether the waiting period is satisfied. Coverage is effective on the **first day of the month following** the first day of employment.

Requirements for Dependent Coverage: A family member of an employee will become eligible for dependent coverage on the first day that the employee is eligible for employee coverage and the family member satisfies the requirements for dependent coverage.

Dependents eligible for coverage include:

1. The employee’s legally married spouse. *Spouse is defined as a person of the opposite sex, who is a husband or wife;*
2. The employee’s child (ren) up until the end of the month in which he or she turns the age of twenty-six (26), including:
 - (a) A natural born child.
 - (b) A stepchild.
 - (c) An adopted child or a child lawfully placed with the employee for legal adoption by the employee. A “child lawfully placed with an employee for legal adoption” refers to a child whom the employee intends to adopt, whether or not the adoption has become final, provided that the child has not attained the age of eighteen (18) as of the date of placement for adoption.
 - (d) An eligible foster child. An eligible foster child is an individual who is placed with the employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.
3. An employee’s unmarried child over the age of twenty-six (26) who is mentally or physically incapable of earning his or her own living due to permanent, chronic, and total disability. The child may obtain continued coverage if, within thirty (30) days after the date coverage would otherwise terminate, the employee submits proof of the child’s incapacity (See Eligibility for Disabled Children); and
4. A minor ward for whom the employee has legal guardianship and who is primarily dependent upon the employee for support and resides with the employee.

Note: The phrase “primarily dependent upon” shall mean dependent upon the covered employee for support and maintenance as defined by the Internal Revenue Code, and the covered employee must declare the dependent for purposes of taking an income tax exemption. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records, or initiation of legal proceedings severing parental rights.

At any time, the Plan Administrator may require documentation proving that a spouse or a child qualifies or continues to qualify as a dependent as defined by this Plan, including but not limited to marriage licenses, birth certificates, and/or a court order establishing a relationship of parent and child. If both husband and wife are employees, their children will be covered as dependents of the husband or wife, but not of both.

Any child of a Plan participant who is an alternate recipient under a Qualified Medical Child Support Order (QMCSO) shall be considered as having a right to dependent coverage under this Plan with no

Pre-existing Condition provisions applied. A participant of the Plan may obtain from the Plan Administrator, without charge, a copy of the procedures governing QMCSO determinations.

Eligibility for Disabled Children: In order for a disabled child to be eligible for coverage under the Plan beyond the end of the month of the child's twenty-sixth (26th) birthday, the child:

1. Must be enrolled in the Plan prior to the age of twenty-six (26).
2. Must be incapable of self-support because of mental retardation or permanent, chronic, and total disability which commenced prior to the age of twenty-six (26).
3. Must be primarily dependent upon the employee.
4. Must be continuously disabled and covered thereafter.
5. Must be considered disabled by the Social Security Administration.

If you believe a covered dependent meets the disability criteria above you may obtain a determination of disability from the Social Security Administration. This information must be submitted to the Plan Administrator within thirty (30) days prior to the covered dependent reaching the age of twenty-six (26). You may be required to submit additional information necessary for completion of the eligibility determination.

If such eligibility is approved, you may be further required (usually not more frequently than once a year) to furnish satisfactory evidence to substantiate the continued eligibility of the covered dependent under the Plan.

Persons Excluded as Non-Dependents: The term "dependent" excludes:

1. Any individuals living in the covered employee's home who do not satisfy the eligibility requirements for dependents as defined by the Plan.
2. The legally separated or divorced former spouse of the employee.
3. Any person who is on active duty in any military service of any country.
4. Any person who is covered under the Plan as an employee.
5. For Plan years beginning before January 1, 2014, any new adult dependent (as of age 18 and as of the Plan Effective date or thereafter) who is eligible to enroll in an employer sponsored plan (including any plan sponsored by that child's spouse) as defined in section 5000A(f)(2) of the Internal Revenue Code other than the group health plan of a parent.

If a person covered under this Plan changes his or her status from employee to dependent or dependent to employee, and the person is covered continuously under this Plan before, during, and after the change in status, credit will be given for deductibles and all amounts applied to benefit maximums.

ENROLLMENT REQUIREMENTS

Enrollment

An eligible employee must enroll for coverage by filling out and signing an enrollment application. The covered employee is also required to enroll for dependent coverage, if dependent coverage is desired.

Under the Plan, members are classified as “timely,” “late” or “special” enrollees depending on when the completed enrollment form is received by the Plan Administrator.

Timely Enrollment

Enrollment is “timely” if the completed enrollment form is received by the Plan Administrator no later than thirty-one (31) days after the person first becomes eligible for coverage, either initially or under a special enrollment period. If the enrollment form is not submitted within this deadline, the person will be a “late enrollee” and will have to wait until the next annual open enrollment period to enroll, unless that person experiences an event permitting mid-year enrollment (See Mid-Year Enrollment Changes).

Open Enrollment

The Plan includes an annual Open Enrollment period. Eligible employees failing to enroll when initially eligible can enroll as “late enrollees” during Open Enrollment without having to satisfy the special enrollment requirements. In addition, members may elect to make changes in their benefit selections during the Open Enrollment period. Changes in enrollment elections will become effective as of the first day of the plan year following the Open Enrollment period. Enrollment elections will remain in effect for the entire plan year and cannot be changed unless the employee experiences certain events that permit mid-year changes (See Mid-Year Enrollment Changes). Members who fail to make an election during Open Enrollment will automatically retain their present benefit elections. Annual Open Enrollment will take place during the month of December for a January 1st effective date.

Late Enrollment

An enrollment is “late” if it is not “timely” that is, if the enrollment is not completed within thirty (30) days after the person first becomes eligible to enroll or during a special enrollment period. Generally, late enrollees may enroll in the Plan only during Open Enrollment (See Open Enrollment above).

Special Enrollment

If an employee or the employee’s dependents are eligible but not already enrolled in the Plan, the employee may request “special enrollment” in the Plan upon either (1) the loss of other health plan coverage or (2) the addition of a new dependent as provided below:

1. **Loss of Other Health Plan Coverage:** An employee or a dependent who is eligible, but not enrolled in this Plan, may enroll if all of the following conditions are met:
 - a. The employee or dependent was covered under another group health plan or had health insurance coverage at the time the individual first became eligible for coverage under this Plan.
 - b. The employee stated in writing at the time Plan coverage was initially offered that the other health coverage was the reason for declining enrollment in this Plan, or the employee provided sufficient documentation of coverage under another plan at the time the initial decision to decline coverage was made.
 - c. The other coverage of the employee or dependent ended because:
 - ◆ The other coverage was COBRA continuation coverage that was exhausted. COBRA continuation coverage is considered exhausted when it ceases for any reason other than the person’s failure to pay premiums on a timely basis or for improper or illegal acts (such as making a fraudulent claim or an intentional misrepresentation).
 - ◆ The other health coverage was not COBRA continuation and was terminated due either to loss of eligibility for the coverage (due to legal separation, divorce, death, termination of employment, or reduction in number of hours of employment) or because employer contributions for the other coverage were

terminated. An individual will not have special enrollment rights if the other coverage ended due to the individual's failure to pay premiums on a timely basis or for cause (such as making fraudulent claims or intentional misrepresentations).

- ◆ The employee or dependent incurs a claim that will meet or exceed the overall annual maximum on all benefits. This right continues until at least thirty (30) days after the earliest date that a claim is denied due to the annual maximum.
 - ◆ The employee or dependent is in a class of coverage that is no longer eligible under the terms of the other Plan.
- d. The employee submits a request for special enrollment in writing to the Plan Administrator no later than thirty (30) days after the date the other coverage terminates. Coverage will be effective no later than the first day of the month following the date the special enrollment request is received.

The above list is not an all-inclusive list of situations when an Employee or dependent loses eligibility. For situations other than those listed above see the Employer.

2. **Newly-Acquired Dependents:** An employee's newly-acquired dependents may enroll in this Plan if:
- a. The employee is a participant under this Plan or, if not a participant at the time, the employee has met the waiting period applicable to becoming a participant and is eligible to be enrolled under this Plan;
 - b. The person becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption; and
 - c. The newly acquired dependent (as of age 18) is not enrolled in an employer sponsored plan.

If the employee is not yet a participant, the employee must enroll during the Special Enrollment Period in order for the newly acquired dependent to be eligible for coverage. In the case of birth or adoption of a child, the spouse of the covered employee may be enrolled as a dependent of the covered employee if the spouse is eligible for coverage.

The Special Enrollment Period is a period of not more than thirty-one (31) days that begins on the date of the marriage, birth, adoption, or placement for adoption.

The coverage of the employee or dependent enrolled during the Special Enrollment Period will be effective:

1. In the case of marriage, not later than the first day of the first month following the date that the completed request for enrollment is received by the Plan Administrator.
2. In the case of a dependent's birth, as of the date of birth.
3. In the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

The "enrollment date" for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the dates a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a waiting period for purposes of the Plan's Pre-Existing Condition exclusion provisions.

Mid-Year Enrollment Changes

Once enrollment elections are made, either during the initial or Special Enrollment periods or during an annual Open Enrollment period, those elections may not be changed and will remain in effect for the entire plan year. However, there are some important exceptions:

1. **Change in Status**

Employees may revoke or modify their enrollment elections mid-year only if they experience a Change in Status that affects their eligibility or the eligibility of their dependents under this Plan. A "Change in Status" is one of the following events:

- a. **Change in legal marital status**, including marriage, death of spouse, divorce, legal separation or annulment.
- b. **Change in number of dependents**, including birth, adoption, placement for adoption, and death of a spouse or other dependent.
- c. **A dependent satisfying or ceasing to satisfy the requirements for coverage.**
- d. **Change in employment status** of the employee, the employee's spouse or other dependent, including termination or commencement of employment, taking or returning from an unpaid leave of absence, change in work site, change in full-time or part-time status, change in hourly or salaried status, change in dependent's eligibility for other employer-based coverage.
- e. **Change in residence** by the employee, the spouse or dependent.

An election change will be approved only if it is consistent with the Change in Status. An election change is "consistent with" a Change in Status if the change is both the result of and corresponds with the Change in Status. For example, if a child ceases to be eligible for coverage because of age, it would be consistent with the Change in Status to drop coverage for the child. However, it would not be consistent with the Change in Status to drop coverage for the employee. As another example, if a spouse is covered under the medical plan of the spouse's employer, and the spouse loses coverage under that plan because of a change from full-time to part-time employment, it would be consistent with the Change in Status for the employee to elect to add the spouse under this Plan.

2. Change in Cost or Coverage

If the cost of benefits increases or decreases during a benefit period, the Plan Sponsor may automatically change employee premium contributions. When the change in cost is significant, employees will be given the opportunity to either increase their contributions or elect a less-costly option (if available).

If there is a significant overall reduction in the Plan's coverage, employees may elect another benefit option (if available). If a new benefit option is added under the Plan, employees will have the right to change their election to the new benefit option.

3. Qualified Medical Child Support Order ("QMCSO")

A QMCSO is a judgment, decree or order resulting from a divorce, legal separation, annulment or change in custody that requires health coverage for an employee's child. An employee may change his or her Plan enrollment elections if the employee becomes subject to a QMCSO that requires the employee to provide (or cancel) health care coverage for a child.

4. Entitlement to Medicare

An employee may change his or her elections for Plan coverage if the employee or any dependent becomes entitled to or loses Medicare coverage.

5. Entitlement to Medicaid or Children's Health Insurance Coverage Reauthorization Act (CHIPRA)

An employee may change his or her elections for PLAN coverage if the employee or any dependent becomes entitled to or loses Medicaid or **CHIPRA**.

Eligible employees enrolled in Medicaid or CHIPRA may enroll in the Plan by submitting a completed Enrollment Change form to the Plan Administrator within 60 days of loss of coverage.

How to Make Mid-Year Enrollment Changes

If an employee experiences an event that allows the employee to make a mid-year enrollment change, the employee must submit a completed Enrollment Change Form to the Plan Administrator no later than thirty-one (31) days after the event occurs. If the employee does not request the coverage change within the specified time limit, the employee will lose the right to make a change allowed by that event.

How to Make Mid-Year Enrollment Changes for Medicaid or CHIPRA

If an employee experiences an event that allows the employee to make a mid-year enrollment change, the employee must submit a completed Enrollment Change Form to the Plan Administrator no later than sixty (60) days after the event occurs. If the employee does not request the coverage change within the specified time limit, the employee will lose the right to make a change allowed by that event.

Effective Date

If approved, the employee's enrollment change(s) will take effect:

1. On the date of the event, in the case of a birth, adoption or placement for adoption.
2. No later than the first day of the month following the date the Plan Administrator receives the employee's completed Enrollment Change Form, in the case of all other enrollment changes.

TERMINATION OF COVERAGE

Rescission: Fraud and intentional misrepresentation of a material fact by employees or covered persons are prohibited. The Plan shall have the right to rescind coverage if a covered person performs an act, practice or omission that constitutes fraud or makes an intentional misrepresentation of a material fact relating to health care or coverage. Thirty (30) days advance written notice will be provided to the person for whom coverage is being rescinded. An employee has the right to appeal a rescission of coverage (See Appeals section). A rescission is a cancellation or discontinuance of coverage that has a retroactive effect.

Employee Coverage Termination: Employee coverage will terminate on the earliest of the following dates:

1. The last day of the month for which premiums were paid when the covered employee terminates employment.
2. The last day of the month on which the covered employee ceases to be in a class eligible for coverage.
3. The date on which this Plan is terminated; or in case of any benefit under this Plan, the date of termination of the specific benefit.
4. The date the covered employee dies.
5. The date the covered employee enters the military service of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding one (1) month in any calendar year.
6. The last day of the month the covered employee fails to make any required contribution for coverage.
7. The last day of the month on which a cancellation or discontinuance of coverage due to rescission is effective retroactively, as provided above.

A covered employee may be eligible for COBRA continuation coverage. For a complete explanation of COBRA availability, see the section entitled COBRA Continuation Coverage.

Coverage Continuation During Periods of Employer-Certified Disability, or Leave of Absence: A person may remain eligible for a limited time if active, full-time work ceases due to disability, leave of absence, or layoff. This continuation will end as follows:

1. **For Employer-Certified Disability leave only.** The end of the **six (6)** calendar month period immediately following the month in which the person last worked as an active employee.
2. **For Leave of Absence.** The end of the **six (6)** calendar month period immediately following the month in which the person last worked as an active employee.

While continued, coverage will remain the same as the coverage in effect on the employee's last day worked as an active employee. However, if benefits are modified or reduced for others in the employee's class, benefits will also be modified or reduced for the continued person.

Coverage Continuation During Family and Medical Leave: Regardless of the leave policies described elsewhere in this Plan, this Plan will at all times comply with the Family and Medical Leave Act of 1993 and applicable regulations issued by the Department of Labor.

An eligible employee who is the spouse, son, daughter, parent or "next to kin" (defined as the nearest blood relative) of a injured US Armed Services member who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to a total of 26 work weeks of leave during a 12-month period to care for the service member. (In compliance with the Family and Medical Leave Act of 1993 and applicable regulations issued by the Department of Labor).

During any leave taken under the Family and Medical Leave Act (FMLA), the employer will maintain coverage under this Plan under the same terms and conditions as coverage which would have been

provided if the covered employee had been continuously employed during the entire leave period. The employee will continue paying any required contributions during the leave.

If Plan coverage is discontinued during the FMLA leave (either upon the employee's election or for failure to pay required contributions during the leave), coverage will be reinstated for the employee and his or her covered dependents if the employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person had coverage under this Plan when the FMLA leave started and will be reinstated to the same extent as the coverage that was in force when coverage was discontinued. For example, Pre-Existing Conditions limitations and other waiting periods will not be imposed unless they were in effect for the employee and/or the employee's dependents when Plan coverage was discontinued for the period of leave.

Rehiring a Terminated Employee: A terminated employee who is rehired will be treated as a new hire and be required to satisfy all eligibility and enrollment requirements, except for an employee returning to work directly from COBRA coverage, in which case that employee does not have to satisfy Pre-Existing Conditions provisions.

Employees on Military Leave: Employees entering into or returning from military service will have the rights mandated by the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). These rights include up to twenty-four (24) months of extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee, and immediate coverage with no Pre-Existing Conditions exclusions applied upon return from military service. These rights apply only to employees and their dependents covered under the Plan before active military service begins.

Plan exclusions and waiting periods may be imposed for any sickness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

Termination of Dependent Coverage: A dependent's coverage will terminate on the earliest of these dates:

1. The last day of the month on which the covered dependent ceases to be an eligible dependent.
2. The last day of the month the covered employee's coverage under this Plan terminates.
3. The last day of the month on which the covered employee ceases to be in a class eligible for dependent coverage.
4. The date this Plan is terminated; in the case of any covered dependent's benefit under this Plan, the date of termination of such benefit.
5. The date the covered dependent enters the military service of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding one month in any calendar year.
6. The last day of the month the covered employee fails to make any required contribution for dependent coverage.

A covered dependent may be eligible for COBRA continuation coverage. For a complete explanation of COBRA availability, see the section entitled COBRA Continuation Coverage.

Certificate of Creditable Coverage

When coverage for an employee or dependent terminates, a certificate of creditable coverage will be mailed to the individual's last known address. A certificate also will be provided if requested within twenty-four (24) months of the termination of coverage. A certificate of creditable coverage may be needed to reduce any pre-existing condition exclusions upon enrollment in another health plan or policy.

DEFINITIONS

Capitalized terms that are used in this Plan shall have the following defined meanings. The inclusion of any phrase or word below does not imply that coverage for the service or supply is provided under the Plan.

ACCIDENTAL INJURY

Accidental injury is an immediate, unforeseen event caused by an external trauma to the body of a covered person, which is unrelated either directly or indirectly to all other causes and which requires treatment by a physician.

ALLOWABLE CHARGE

The allowable charge is the lesser of the actual negotiated or the Plan Allowance fee for services.

AMBULATORY SURGICAL CENTER

An ambulatory surgical center is any licensed public or private establishment with an organized medical staff of physicians with permanent facilities that (i) is equipped and operated primarily for the purpose of performing surgical procedures; (ii) provides continuous service of physicians and registered professional nurses whenever a patient is in the facility, and (iii) which does not provide services or other accommodations for patients to stay overnight. Charges are covered only for facilities that are approved by the Joint Commission on Accreditation of Hospitals.

CLAIM

A claim is any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's procedures for making benefit claims.

COBRA

"COBRA" stands for the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and any applicable regulations.

CO-INSURANCE RATE

Co-insurance rate is the rate or percentage that the Plan pays for Covered Medical Expenses after the calendar year deductible and/or co-pay has been met, subject to any applicable maximums.

CO-INSURANCE LIMIT

Except for expenses expressly disallowed, the co-insurance limit is the maximum amount that a covered person must pay for covered expenses, during the calendar year before the co-insurance rate is increased to 100% for the remainder of the calendar year. The Plan has individual as well as family annual co-insurance limits.

CONCURRENT CARE CLAIM

There are two types of Concurrent Care Claims:

1. A claim to extend coverage for a course of treatment beyond a previously approved period of time or number of treatments.
2. A claim regarding reduction or termination of coverage by the Plan before the end of a previously approved period of time or number of treatments.

CO-PAY OR CO-PAYMENT

Co-pay is the amount that the covered person is required to pay directly to the Provider each time the covered person receives services. The co-pay is separate from and does not accrue towards the deductible or co-insurance limits. Co-payments are required for certain Covered Expenses even if the deductible requirements have been met or the co-insurance limit has been reached.

COSMETIC SURGERY

Cosmetic surgery is a procedure performed primarily to preserve or improve appearance rather than to restore the anatomy and/or functions of the body that are lost or impaired due to an illness or injury.

COVERED MEDICAL EXPENSES

Covered medical expenses are expenses for medical care provided to an individual while covered under the Plan and for which coverage is available under the Plan (see the Schedule of Benefits and Covered Medical Expenses sections for listings). Benefits for Covered Medical Expenses are subject to all the terms, conditions and limitations of the Plan.

CUSTODIAL CARE

Custodial care refers to services and supplies, including room and board and other institutional services, which are provided to an individual, whether disabled or not, primarily to assist him in the activities of daily living. These services and supplies are classified as custodial care regardless of the practitioner or provider who prescribes, performs or recommends the services.

DEDUCTIBLE

Deductible is the “out-of-pocket” amount that a covered person must pay before the Plan will pay Covered Expenses. The deductible is subtracted from the allowable charge before the out-of-pocket amount is calculated.

Calendar Year Deductible - A covered person’s deductible requirement will be met when Covered Medical Expenses paid by that person during each calendar year equal the deductible amount. The covered person is responsible for paying the calendar year deductible. The Plan will not reimburse the covered person for this expense.

Family Deductible – The family deductible is satisfied when the sum of all deductible payments for covered family members meets the calendar year family deductible amount. Any covered charges incurred by any covered family member after the family deductible is satisfied will be paid at the co-insurance rate up to applicable plan limits for the remainder of the calendar year.

DENTAL SERVICES

Dental services are procedures involving the teeth, gums or supporting structures.

DURABLE MEDICAL EQUIPMENT

Durable medical equipment is a device that is able to withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, and is prescribed by a physician and appropriate for use in the home.

EFFECTIVE DATE

Effective date is the date on which an employee or dependent is covered by the Plan.

ELIGIBILITY DATE

Eligibility date is the date on which an employee or dependent becomes eligible to participate in the Plan.

EMERGENCY CARE

Emergency care is care or services received due to a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson possessing an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to place the health of the individual in serious jeopardy, cause serious impairment to bodily functions, or cause serious dysfunction of any bodily organ or part.

EMERGENCY ROOM PHYSICIANS

Emergency room physicians are physicians who provide emergency services located in hospitals or in minor emergency centers. Care by emergency room physicians is not given on an on-going basis, and emergency room physicians do not admit and follow patients when hospitalized. For the purposes of this Plan, emergency room physicians are not considered to be primary care physicians.

EMPLOYEE

Employee is any person who is employed by the Employer, excluding any leased employees, independent contractors, or contract employees. Individuals classified by the Employer as leased employees, independent contractors or contract employees shall be excluded from Plan participation even if they are subsequently determined to be common law employees by any court or government agency.

EMPLOYER

Employer is **Averett University** and any affiliates that participate in the Plan for the benefit of eligible employees.

ENROLLMENT DATE

Enrollment date is the first day of coverage or, if the Plan has a waiting period, the first day of the waiting period. The enrollment date for a late enrollee or any person who enrolls during a special enrollment period is considered to be the first date of coverage under this Plan.

EXPERIMENTAL OR INVESTIGATIONAL

A treatment (other than covered off-label drug use) will be considered to be experimental or investigational if any of the following conditions are met:

1. The treatment is governed by the Food and Drug Administration (FDA) and the FDA has not approved the treatment for the particular condition at the time the treatment is provided.
2. The treatment is the subject of on-going Phase I, II, or III clinical trials as defined by the National Institute of Health, National Cancer Institute or FDA.
3. There is documentation in published U.S. peer-reviewed medical literature stating that further research, studies, or clinical trials are necessary in order to determine the safety, toxicity or efficacy of the treatment.

FACILITY

A Facility is a healthcare institution which meets all applicable state or local licensure requirements, and which includes, but is not limited to the following: hospitals, skilled nursing facilities, intermediate care facilities, ambulatory surgical centers, free standing dialysis facilities or lithotripter centers.

FORMULARY DRUGS

Formulary drugs are specified alternative prescription drugs for specific brand name drugs. Formulary drugs have been reviewed for safety, quality, effectiveness, and cost. A list of the Plan's formulary drugs is included in the member information packet. The formulary drug list is periodically reviewed and modified by a panel of physicians and pharmacists.

FULL-TIME STUDENT

A full-time student is a student enrolled for a number of hours, credits or courses considered full-time by the accredited educational institution where he or she is in attendance.

GENERIC DRUGS

"Generic drugs" is a term used for prescription drugs identified by their chemical name. When the patent has expired on a brand name drug, the FDA permits manufacturers other than the original developer to create a bioequivalent of the brand name drug and make it available to the public. Generally, more than one manufacturer will create the generic version, although in many cases the same pharmaceutical firm that produces the brand name drug also makes the generic version. This prompts competitive pricing of the generic version and usually results in a less expensive drug.

HOME HEALTH CARE

Home Health care is a formal program of care and treatment that is performed in the home of a person, is prescribed by a physician, and is prescribed in lieu of treatment in a hospital or skilled nursing facility or results in a shorter hospital or skilled nursing facility stay. The home health care program must be organized, administered, and supervised by a hospital or qualified licensed personnel under the medical direction of a physician.

HOSPICE

Hospice is an agency that provides counseling and medical services and may provide room and board for a terminally ill individual. Covered Hospice services must meet all of the following requirements:

1. It is licensed and has obtained any required state or governmental Certificate of Need approval.
2. It is under the direct supervision of a physician, has a nurse coordinator who is a registered nurse (R.N.) and provides service twenty-four (24) hours a day, seven (7) days a week.
3. It is an agency that has as its primary purpose the provision of hospice services.
4. It has a full-time administrator and maintains written records of services provided to the patient.

HOSPITAL

An institution is considered to be a hospital if it fully meets each of the following requirements:

1. It maintains on the premises, on an inpatient basis, diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons, by or under the supervision of a staff of duly qualified physicians.
2. It continually provides on the premises twenty-four (24) hours a day registered nurse (R.N.) services.
3. It is recognized as a hospital by the Joint Commission on Accreditation of Hospitals.
4. It charges fees for its services.

The term "hospital" will not include, nor will the term "covered charges" include charges incurred in connection with confinement in any institution or part thereof used principally as a rest or nursing facility or a facility for custodial care. Facilities for the treatment of mental health disorders and substance use disorders must be licensed by the State Board of Health and approved by the Joint Commission on Accreditation of Hospitals.

HOSPITAL PER ADMISSION DEDUCTIBLE

The hospital per admission deductible applies to each hospital admission. It is separate from the individual deductible, family deductible, and physician co-payment, and does not accrue toward the co-insurance limit.

HOSPITAL PER OCCURRENCE DEDUCTIBLE

The hospital per occurrence deductible applies to each hospital and/or outpatient facility encounter. It is separate from the individual deductible, family deductible, physician co-payment, and does not accrue toward the co-insurance limit.

ILLNESS

An Illness is a mental or physical disease or infirmity, including pregnancy or pregnancy-related conditions.

INJURY

An Injury is the accidental bodily harm to a covered employee or covered dependent.

IN-NETWORK PROVIDERS

An in-network provider is one who has elected to participate directly in the Plan or through a network supplementary to the Plan. A directory of in-network providers is available from the Plan Administrator. This Plan may reimburse differently based on whether the hospital/facility, physician, or other medical service provider participates directly in the Plan or through a network supplementary to the Plan.

MEDICALLY NECESSARY

Care and treatment is "medically necessary" if the Plan Administrator or its delegate determines that the care and treatment meets all of the following conditions:

1. It is recommended and provided by a licensed physician, dentist or other medical practitioner who is practicing within the scope of his or her licenses.
2. It is appropriate for the symptoms and is consistent with the diagnosis, if any. "Appropriate" means that the type, level and length of services and setting are needed to provide safe and adequate care and treatment.
3. It is generally accepted as the standard of medical practice and care for the diagnosis and treatment of the particular condition.
4. It is specifically allowed by the licensing statutes which apply to the provider who renders the service.
5. It is ordered and documented in a timely fashion in the covered person's medical record.
6. If an inpatient procedure, it could not have been adequately performed in an outpatient facility.

The fact that a physician may prescribe, recommend, approve or view a service or supply, as medically necessary does not make that service or supply medically necessary under the Plan. The Plan Administrator has sole and complete discretionary authority to determine whether the service or supply is medically necessary as defined under the Plan and may seek assistance or guidance for its determination from the Medical Department of Primary PhysicianCare, Inc.

Please Note: Medical Necessity is not a guarantee of coverage.

MEMBER

Member is an employee or dependent that satisfies the requirements outlined in the Eligibility section and is enrolled in the Plan.

MENTAL HEALTH DISORDERS

A mental health disorder is a disease or condition, except those related to a substance use disorder, that is classified as a mental or nervous disorder in the current edition of Internal Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), U.S. Department of Health and Human Services Publication No. (PHS) 89-1260, or in any subsequent revision of the International Classification of Diseases published by the U.S. Government Printing Office.

OUT-OF-NETWORK

As outlined in the Schedule of Benefits, this Plan may reimburse differently based on whether the hospital, facility, physician or other medical service provider is contracted as a participating provider with the Plan or through an in-network provider network supplementary to the Plan. An "out-of-network provider" is one who has not elected to participate in the Plan or through an in-network provider network supplementary to the Plan. All charges by a out-of-network provider are subject to the Plan's definition of Plan Allowance.

OUT-OF-AREA BENEFITS

Out-of-area benefits apply to members who reside in a location that does not offer access to a sufficient number or specialty of in-network providers. The Plan Administrator determines which members are covered through the out-of-area provision. Out-of-area benefits also apply to emergency care.

OUTPATIENT/REFERENCE DIAGNOSTIC LAB CHARGES

Charges incurred from independent freestanding reference labs and/or charges incurred on an outpatient basis from a hospital and/or facility.

PAIN THERAPY / PAIN MANAGEMENT

Pain therapy/pain management treatment includes but is not limited to epidural steroid injections, nerve blocks, pain center (facility) fees, and all other related professional services. This does not include services received as a result of malignancy.

PARTICIPATING PHARMACY

Participating pharmacy is any pharmacy licensed to dispense prescription drugs that is included as a participant in the program offering pre-paid benefits to eligible Plan participants.

PHYSICIAN

The term physician is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is legally qualified and licensed without limitation to practice medicine, surgery or obstetrics at the time and place service is rendered. For services covered by this Plan and for no other purpose, doctors of dental surgery, doctors of dental medicine, doctors of podiatry or surgical chiropody, chiropractors, optometrists, licensed psychologists, physical therapists, occupational therapists, speech therapists, physician assistants, nurse practitioners, licensed medical social workers, and midwives are deemed to be physicians when acting within the scope of their state licenses. Physician assistants, nurse practitioners (including Certified Registered Nurse Anesthetist also known as CRNA's), and midwives must practice under the direct supervision of a physician (M.D. or D.O.). Physical, occupational and speech therapy must be prescribed by a physician (M.D. or D.O.). PhDs in psychology are also considered covered providers.

Please Note: CRNA charges, billed in addition to an anesthesiologist will not be covered under the Plan Allowance Charges or the contracted network allowances.

PLAN ADMINISTRATOR

Plan Administrator is the Plan Sponsor or the person or committee appointed by the Plan Sponsor to carry out the administration and management of the Plan. The Plan Administrator has sole and complete discretionary authority to interpret the Plan, including those provisions relating to eligibility and benefits due under the Plan, and to make all determinations, including factual determinations, arising under the Plan.

PLAN ALLOWANCE

The Plan allowance is the amount that the Plan Administrator in its sole discretion, has determined to be the maximum amount payable for an out-of-network provider covered service. Charges in excess of the Plan allowance will not be considered Covered Medical Expenses under this Plan. The Plan will reimburse the actual charge billed if it is less than the Plan allowance. A complete listing of the Plan Allowance charges is located at www.primarypc.com/providers. The Plan allowance only applies to out-of-network providers (see Schedule of Benefits). This provision does not apply to Dental benefits.

PLAN PARTICIPANT

Plan participant is an employee of the Employer who is covered under the Plan.

PLAN SUPERVISOR

Plan Supervisor is the person or firm employed by the Plan Sponsor to provide administrative services to the Plan including the processing and payment of claims.

POST -SERVICE CLAIM

Post-Service Claims are any claims filed for payment of benefits after medical care has been received.

PRE-EXISTING CONDITION

A Pre-Existing Condition is a condition for which medical advice, diagnosis, care or treatment was recommended or received within six (6) months of the person's enrollment date under this Plan.

Genetic information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medications. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by or received from a physician or other health care provider.

PRE-SERVICE CLAIM

Pre-Service Claim is a claim for a benefit under this Plan when the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. For more information, see the Care Management Services section.

PRIMARY CARE PHYSICIAN (PCP)

A PCP is a physician specializing in internal medicine, general practice, family practice, pediatrics, and/or obstetrics or gynecology chosen by the covered person to manage the continuity of his or her medical care. Certified Physician's Assistants (PAC's) and Certified Nurse Practitioners (CNP's) supervised by the primary care physician may also be considered PCP's under the Plan as long as they practice in the same location as the PCP.

PRIMARY CARE SERVICES

The Plan encourages the selection of a primary care physician at the time of enrollment in the Plan. **A primary care physician is a general internist, pediatrician, family physician or a gynecologist.** The benefits listed in the Primary Care Services section apply only when provided in the office of a primary care physician. The Plan Allowance limitations may apply.

RETIREMENT

Retirement begins on the first day on which retirement benefits become effective under:

1. Any plan of a federal, state, county, municipal or association retirement system for which the employee is eligible as a result of employment with the Employer.
2. Any plan which the Employer sponsors.
3. Any plan to which the Employer makes contributions or has made contributions.
4. The United States Social Security Act or any similar plan or act. If the employee is in active employment and is receiving disability benefits under the United States Social Security Act or any similar plan or act, the employee will not be considered retired.

SICKNESS

An illness or disease of a covered employee or covered dependent including congenital defects or birth abnormalities.

SKELETAL ADJUSTMENT

Skeletal Adjustment is the treatment of the skeletal system performed by external manipulation including, but not limited to, vertebral manipulation and associated adjunctive therapy.

SLEEP DISORDER

Sleep Disorders include but are not limited to sleep apnea, snoring, and narcolepsy.

SUBSTANCE USE DISORDER

A substance use disorder is the continued use or abuse of, and/or dependence on, legal or illegal substance(s), despite significant consequences or marked problems associated with the use as defined, described, or classified in the most current version of Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

TEMPOROMANDIBULAR JOINT SYNDROME (TMJ)

TMJ is an abnormal condition characterized by facial pain and by mandibular dysfunction usually caused by a defective or dislocated temporomandibular joint.

TRANSPLANT

See Organ Transplant Program under the Care Management Services section.

URGENT CARE CENTERS

An urgent care center is a public or private establishment that is equipped and operated primarily for the purpose of providing emergency treatment or performing surgical procedures and which does not provide services or other accommodations for patients to stay overnight. An urgent care center must be staffed by physicians and registered nurses.

URGENT CARE CLAIM

An Urgent Care Claim is any claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of the attending or consulting physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim. A physician with knowledge of the claimant's medical condition may determine if a claim is one involving urgent care. If there is no such physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson possessing an average knowledge of health and medicine may make the determination.

WEEKEND ADMISSIONS

If a covered person is admitted to a hospital as an inpatient on Friday after 5:00pm, Saturday, or Sunday, no benefits will be paid for charges incurred on those days unless:

1. The confinement was for the birth of a child; or
2. Surgery is scheduled within twenty-four (24) hours following admission to the hospital and was pre-certified; or
3. The confinement was a medical emergency.

If a hospital confinement is disallowed because of the above, the disallowed amount will **NOT** accrue toward the hospital deductible or co-insurance limit.

CARE MANAGEMENT REQUIREMENTS

The Plan features certain care management services designed to help ensure that all covered persons receive necessary and appropriate health care while avoiding unnecessary expenses when a hospital confinement, a surgical procedure or certain other care is proposed. It is important that covered persons use the program and follow all necessary steps as required. Failure to comply with these requirements will result in a penalty to the provider and/or member and can cause benefits to be reduced or denied. See “Plan Service Guide” for Pre-Certification numbers. **Failure to comply with these requirements will result in a 50% reduction of benefits.**

1. PRE-CERTIFICATION PROCESS

In order to receive full benefits for the services listed below, the covered person must obtain pre-certification prior to receiving the services or treatment. Pre-certification is the responsibility of the member. If the member is unsure whether pre-certification has been made, he or she should call to verify.

7 day advance notice (pre-certification) is required for any non-emergency admission from the pre-certification list below:

Services Requiring Pre-certification:

- ◆ Angioplasty
- ◆ Cardiac Cath
- ◆ Cardiac/Pulmonary Rehabilitation
- ◆ Dialysis
- ◆ Durable Medical Equipment (over \$500)
- ◆ Endoscopies / Bronchoscopy / Colonoscopy / Sigmoidoscopy (if performed in the hospital)
- ◆ Home Health Care / Home Health Services / Hospice
- ◆ Inpatient Hospital Care / Inpatient Mental Health
- ◆ Inpatient Rehabilitation
- ◆ Magnetic Resonance Imaging (MRI)
- ◆ Non-Emergent Ambulance Transportation- Non reimbursable except hospital to hospital or with appropriate letter of medical necessity.
- ◆ Oncology / Chemotherapy / Radiation Therapy
- ◆ Outpatient Pain Management Services
- ◆ Outpatient Surgery (Hospital or Freestanding surgical center)
- ◆ PET Scans
- ◆ Pregnancy / Maternity Care (at time of diagnosis of pregnancy)
- ◆ Skilled Nursing Facility Admissions
- ◆ Transplants including Evaluations
- ◆ Any services performed by a non-participating provider that cannot be performed by a network Provider

Pre-certification Phone Number: (434) 799-0702 or (877) 846-8930

Hospital Admissions

For Emergency Admission: The covered person or an authorized representative of the family or the admitting office must call within forty-eight (48) hours or by the end of the first business day after admission.

For Non-Emergency Admission: The covered person or an authorized representative of the family or the admitting office must have the hospital/facility days certified by calling Gateway Health

Alliance's Medical Department Medical Department when planning a future admission for the covered person. This must be done at least seven (7) days before the scheduled date of admission.

Pre-certification is the ultimate responsibility of the covered person. If the member is unsure whether pre-certification has been made, he or she should call to verify.

Pre-Certification Penalty

See Schedule of Benefits.

2. UTILIZATION REVIEW

When a hospital admission or other admission requiring pre-certification is recommended, the Medical Department of Gateway Health Alliance must be contacted for utilization review.

Information Needed for Review. The following information will be needed for a review:

1. Employee name and member number.
2. Employer's name.
3. Patient's name and date of birth.
4. Name, address, and phone number of admitting/attending physician.
5. Date of hospital/facility admission.
6. Hospital/facility name, address, and phone number.

Physician Contact. Gateway Health Alliance's Medical Department will contact the attending physician as part of the pre-certification process to:

1. Discuss the admitting diagnosis and the procedure(s) to be performed.
2. Determine if an outpatient option applies and if the procedure(s) can/should be performed on an outpatient basis.
3. Document any change in diagnosis or treatment.
4. Agree upon the number of days in the hospital/facility for the specific procedure(s).

Hospital/Facility Contact. During the covered person's inpatient stay, Gateway Health Alliance's Medical Department will contact the hospital/facility as part of the pre-certification process in order to determine that:

1. The admission takes place upon the determined date and the prescribed care is being administered.
2. The patient is actually receiving the treatment outlined by the physician.
3. The patient is released from the hospital/facility when inpatient care is no longer needed.

Inpatient Extension Process. If, in the opinion of the patient's physician, it becomes necessary to extend the stay, then the physician or the hospital/facility may request an extension of the certification by calling Gateway Health Alliance's Medical Department. This must be done no later than on the last day that has already been certified.

Treatment Disagreements. When there is a disagreement between the Gateway Health Alliance medical review coordinator and the attending physician as to the length of stay, course of treatment, or any other medical need, the physician may proceed as he sees fit, although covered benefits could be affected. The attending physician always has control of all treatment issues once the patient is admitted to the hospital/facility. The role of the Plan Administrator and of Gateway Health Alliance's Medical Department in the utilization management process pertains solely to coverage under the terms of this Plan.

Pre-Admission Certification is not a guarantee of either payment of benefits or the amount of benefits. Eligibility for and payment of benefits are subject to the terms of this Plan. If pre-certification is not obtained due to special circumstances and the member notifies the Plan Supervisor promptly of those circumstances, the applicable benefit reductions and penalties may be waived. Waivers will be applied in a consistent, nondiscriminatory manner to all similarly situated persons.

3. CASE MANAGEMENT

If a covered person suffers an injury or illness for which health care needs are likely to be very complex and/or costs extremely high, the case may be referred for case management by Primary PhysicianCare. After reviewing the case, the case manager may decide that an alternative plan of treatment is available. If an alternative plan of treatment is approved, benefits other than those described in this Summary Plan Description as Covered Medical Expenses may be payable if recommended by the case manager. Recommendations are made only on a prospective basis and only if the treatment is agreed to by the patient, the attending physician, and case management on behalf of the Plan. The Plan reserves the right to pay in-network benefits to any provider willing to enter into a negotiated arrangement through the case management program.

4. ORGAN/TISSUE TRANSPLANT PROGRAM

The Plan covers certain organ transplant procedures when a covered person is the recipient of the organ. The co-insurance limit will not apply for the transplant procedure unless (a) the procedure is arranged through case management and (b) the procedure is performed at an approved facility or hospital.

1. Eligible charges incurred by the covered person will be paid for the following donor expenses directly related to the procurement of a living or cadaver human organ for any covered transplant procedure:
 - a. Testing to identify a suitable donor.
 - b. Transportation of a donor to and from the site of the transplant procedure.
 - c. Life support of a donor to and from the site of the transplant procedure.
 - d. Hospital, medical and surgical charges related to the removal of the donated organ(s).
 - e. Storage and transportation of donated organ(s).
2. Charges incurred for organ transplant surgery will be paid for the following organ transplant categories to allow for reasonable and medically necessary care and treatment. All other organ transplants not specifically mentioned here will be excluded and no benefits will be paid for any charges associated with them. **Covered organ transplant categories are:**
 - a. bone marrow
 - b. heart
 - c. lung
 - d. kidney
 - e. pancreas
 - f. liver
 - g. peripheral stem cell
3. Covered Medical Expenses will include:
 - a. Use of temporary life-support equipment, pending the acquisition of “matched” human organs.
 - b. Multiple transplants during one operative session.
 - c. Replacement(s) or subsequent transplant(s).
 - d. Follow-up expenses for covered services (including immuno-suppressant therapy).

4. Non-covered expenses will include:
 - a. Any financial consideration to a donor other than expenses directly related to the performance of the surgery.
 - b. Any animal organ or mechanical organ.
 - c. Anything excluded or limited as stated in the Plan.

Additional Covered Benefits. In addition to the standard organ transplant benefit, the following benefits may be available when a covered person participates in the Plan's Organ Transplant Program. This Organ Transplant Program is an enhancement to the standard organ transplant benefit and participation in the program is voluntary. Additional covered benefits include:

1. Access to over forty (40) "Transplant Centers of Excellence" across the United States, as well as outpatient peripheral stem cell facilities and transplant facilities in Great Britain;
2. Reimbursement for travel and lodging expenses incurred during the transplant procedure immediately prior to and after the transplant up to a \$10,000 maximum for the covered person and a companion. Travel and lodging discounts are also available with select airlines and hotels;
3. Waiver of the covered person's deductible and out-of-pocket expenses up to a maximum of \$1,500; and
4. Services of a transplant facilitator who will coordinate the entire transplant process.

The services listed above are only available when a covered person fully participates in the Organ Transplant Program and meets all of the following requirements:

1. Pre-certification of the proposed organ transplant must be made by the covered person or the physician as soon as the covered person is identified as a potential transplant candidate. **Pre-certification is made by calling Gateway Health Alliance at 1-877-846-8930;** and
2. All organ transplant services must be rendered at a "Transplant Center of Excellence" facility in the Transplant Program Network. Gateway Health Alliance will coordinate selection of the facility with the patient and physician.

If these requirements are not met, Organ Transplant Program benefits may be reduced.

Once enrolled in the program, a transplant facilitator will be assigned. This facilitator will coordinate the entire organ transplant process with the patient and physician, from hospital selection to travel arrangements to prescription drug options. Information regarding the network hospitals and other relevant information will be forwarded to the covered person and the physician. The transplant facilitator will work with the covered person, the physician, and the Plan Supervisor to assure quality and continuity of care throughout the process, pre-transplant to post-transplant, including organ harvest.

ONCOLOGY PHARMACEUTICAL AND CLINICAL MANAGEMENT PROGRAM

This provision describes a special medical management program designed for certain aspects of care received by cancer patients.

This Plan includes an oncology management program administered by Biologics, Inc, a company specializing in oncology management. The purpose of this oncology management program is to assist the covered person and the covered person's oncologist during the covered person's course of cancer treatment when administered in an outpatient setting (e.g. in the physician's office or other covered outpatient setting). The program only applies to the chemotherapy plan of treatment and other oncology pharmaceuticals to be used in connection with the covered person's cancer treatment received on an outpatient basis.

Unless the treating oncologist has entered into an agreement with the oncology management program to accept other reimbursement rates, the payment for all drugs used in the treatment of cancer shall be limited to the rate of Average Sales Price ("ASP") plus 10% for Brand and Generic. Average Sales Price is updated quarterly by Medicare.

In order to receive benefit payments under the Plan, the oncologist's plan of treatment must be received by Biologics, and deemed not to be Experimental and/or Investigative. The use of a drug will not be considered Experimental and/or Investigative where the use of the drug has been recognized as safe and effective for the treatment of the specific type of cancer in the Drugs and Biologics Compendium published by the National Comprehensive Cancer Network, Thomson Micromedex DrugDex and Clinical Pharmacology.

COORDINATION OF BENEFITS

Coordination of Benefits. When two (2) or more plans cover the incurred expenses, coordination of benefit rules will apply to determine the order in which those plans pay for covered charges. When a covered person is covered by this Plan and another plan, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the coordination rules is the primary plan and will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable expenses.

Generally, unless a specific rule applies, where a claim is submitted for payment under this Plan of Benefits and one or more other Plans, this Plan of Benefits is the Secondary Plan.

Benefit Plan. The Plan will coordinate medical and dental benefits provided under another benefit plan. The term “benefit plan” includes any one of the following plans:

1. Group or group-type plans, including franchise or blanket benefit plans.
2. Group practice and other group pre-payment plans.
3. Federal government plans or programs, including Medicare, Medicaid and **CHIPRA**.
4. Other plans required or provided by law.
5. No fault auto insurance, by whatever names it is called, when not prohibited by law.

Allowable Charges. For a charge to be allowable it must be within the Plan Allowance charge and at least part of it must be covered under this Plan.

In the case of health maintenance organization (HMO) plans, this Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. In addition, when an HMO pays its benefits first, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO had the covered person used the service of an HMO provider.

In the case of service type plans, where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

When coverage of medical expenses is available under an automobile insurance policy, coverage under this Plan is limited to covered expenses in excess of those available under the automobile insurance policy, without reimbursement for any deductibles under the automobile insurance policy. This Plan always shall be the secondary plan regardless of the individual’s election under PIP (personal injury protection) coverage with the automobile insurance carrier.

Benefit Plan Payment Order. When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules:

1. Plans that do not have coordination provisions will pay first. Plans with coordination provisions will be considered after those without them.
2. Plans with coordination provisions will pay benefits in accordance with the following rules, whichever applies first, up to the allowable charge:
 - (a) The plan that covers the person directly, as an employee, member, or subscriber, (Plan A) pays before the plan that covers the person as a dependent (Plan B).
Special Rule. If (i) the person covered directly is a Medicare beneficiary and (ii) Medicare is secondary to Plan B and (iii) Medicare is primary to Plan A (for example, if the person is retired), then Plan B will pay before Plan A.
 - (b) A plan which covers a person as an employee who is neither laid-off nor retired (or as a dependent of such employee) pays before a plan which covers that person as a laid-off or retired employee (or as a dependent of such laid-off or retired employee).

If the other benefit plan does not have this rule, and if, consequently, the plans do not agree on the order of benefits, this rule does not apply.

- (c) A plan which covers a person as an employee who is neither laid-off nor retired (or as a dependent of an employee who is neither laid-off nor retired) pays before a plan which covers the person as a COBRA beneficiary.
 - (d) When a child is covered as a dependent and the parents are not separated or divorced, these rules will apply:
 - (i) The plan of the parent whose birthday falls earlier in a year pays before the plan of the parent whose birthday falls later in that year; and
 - (ii) If both parents have the same birthday, the plan that has covered the patient for the longer time pays before the plan that covers the other parent.
 - (e) When a child is covered as a dependent and the parents are divorced or legally separated, these rules will apply:
 - (i) If there is a court decree that establishes that one parent is financially responsible for the health care expenses of the child, the plan of that parent will be considered before other plans that cover the child as a dependent.
 - (ii) If there is a court decree that states that the parents share joint custody of the child without stating that one of the parents is financially responsible for the child's health care expenses, then the plans will apply the birthday rules outlined under (d) above to determine which plan is primary.
 - (iii) If there is no court decree, then:
 - (a) If the parent with custody of the child has not remarried, the plan of the parent with custody will pay before the plan of the parent without custody.
 - (b) If the parent with custody of the child has remarried, the plan of the parent with custody will be considered first. The plan of the stepparent that covers the child as a dependent will be considered next. The plan of the parent without custody will be considered last.
 - (f) If there is still a conflict after these rules have been applied, the plan that has covered the patient for the longer time, will be considered primary.
3. Medicare will pay primary, secondary, or last to the extent required by federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled in both of these parts.

Claims Determination Period. Benefits will be coordinated on a calendar year basis. This is called the claims determination period.

Right to Receive or Release Necessary Information. This Plan may give or obtain needed information from another insurer or any other organization or person for purposes of coordinating benefits. This information may be given or obtained without the authorization of or notice to the person that is the subject of the information. When a claim for benefits is filed, information must be provided regarding any other plans which also cover those claims.

Facility of Payment. This Plan may repay other plans for benefits paid by the other plans that the Plan Administrator determines should have paid by this Plan. That repayment will count as a valid payment under this Plan.

Right of Recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case, this Plan may recover the amount paid from the other benefit plan or from the covered person. That repayment will count as a valid payment under the other benefit plan. In addition, this Plan may pay benefits that are later determined to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

PLEASE NOTE: If other health coverage is available from any other source that provides for coordination, including Medicare, Medicaid, TRICARE coverage and **CHIPRA**, amounts paid by the Plan do not accrue toward the co-insurance limit.

COBRA CONTINUATION COVERAGE

Federal law gives certain persons the right to continue Plan coverage beyond the date it would otherwise terminate. The entire cost (plus an administration fee allowed by law) must be paid by the continuing person. Continuation coverage will end if the covered individual fails to make timely payment of the required contribution or premium. This law is referred to as “COBRA,” which stands for the Consolidated Omnibus Budget Reconciliation Act of 1985.

What COBRA Provides

COBRA coverage is available to the member and covered dependents, if coverage under the Plan would otherwise end because:

1. The member’s employment ends for any reason other than gross misconduct.
2. The member’s regularly scheduled work hours are reduced so that the Plan’s eligibility requirements are no longer met.

In addition, COBRA coverage is available to the member’s covered dependents if the dependent’s coverage would otherwise end because of:

1. The member’s death, divorce, legal separation.
2. The member’s entitlement to Medicare.
3. The dependent ceased to be eligible for Plan coverage (for example, due to age).

The Employer filing a proceeding in bankruptcy under title 11 of the United States Code is a qualifying event for retired employees and their dependents covered under the Plan if the bankruptcy results in loss of coverage under the Plan.

Under COBRA, “qualified beneficiaries” – the member and the member’s eligible covered dependents – may continue the same coverage in effect before the COBRA qualifying event. If coverage for similarly situated active employees or their dependents is modified, COBRA coverage will be modified in the same manner.

A newly-acquired dependent during the period of COBRA continuation coverage will be entitled to receive coverage under the Plan for the duration of the COBRA coverage period. The child must be enrolled within 30 days of the birth, adoption or placement for adoption, otherwise the member will have to wait until the next annual open enrollment period to enroll the child.

Maximum COBRA Continuation Period

If elected, COBRA coverage begins as of the date Plan coverage would otherwise end. The maximum duration of COBRA continuation varies depending on the reason the member or the member’s covered dependents are eligible for COBRA.

For Up to 18 months. Coverage may continue for the member and covered dependents for **up to 18 months** if coverage under the Plan would otherwise end because of a reduction in work hours or termination of employment for reasons other than gross misconduct, fraud, or intentional misrepresentation of a material fact.

For Up to 29 months. If the Social Security Administration determines that a member or a covered dependent is disabled within 60 days of the date coverage ends due to a reduction in hours or termination of employment, COBRA coverage for the disabled individual and non-disabled family members entitled to COBRA may be continued for **up to 29 months** from the date of the qualifying COBRA event. The Plan Administrator must be notified in writing of the disability within 60 days after the latest of: (a) the Social Security’s determination of disability, (b) the date on which the

qualifying event occurs, or (c) the date on which notification is received of the requirement to provide the notice of disability. The Plan Administrator must also be notified within 30 days if Social Security Administration determines that the disabled individual is no longer disabled. Notices about disability must be provided to the Plan Administrator in writing at the address listed in the Plan Information section.

For Up to 36 Months. COBRA coverage may continue for covered dependents for **up to 36 months** if their coverage would otherwise end because of (1) the member's death, divorce or legal separation, (2) the member's entitlement to Medicare, or (3) the member's dependent child ceases to be eligible for Plan coverage. If any of these qualifying events occurs while the dependents are covered under COBRA due to an event resulting in 18 months of COBRA coverage (see above), coverage may continue for a total of 36 months from the date of the first COBRA qualifying event, but only if the second qualifying event would have caused the covered dependent to lose coverage had the first qualifying event not occurred. The Plan Administrator must be notified within 60 days of the second qualifying event, as described below, to extend coverage.

Notice of Some Qualifying Events

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. If the qualifying event is termination of employment, reduction in hours, death, or entitlement to Medicare, the Employer must notify the Plan Supervisor within 30 days of such event.

However, for other qualifying events (divorce, legal separation, or a dependent child's loss of eligibility), the member or the member's dependents must notify the Plan Administrator within 60 days of the qualifying event or the date coverage would terminate due to that event, whichever is later. If notice is not provided within this time limit, COBRA continuation coverage will not be available to dependents. The Plan Supervisor will provide notification in writing if COBRA continuation is not available after one of these qualifying events.

In addition, if while covered under COBRA for 18 months, covered spouse or dependents experience a second qualifying event that allows extension of COBRA coverage to 36 months, the Plan Administrator must be notified in writing within 60 days of the second qualifying event. Failure to provide timely notice will result in loss of eligibility for the extension on account of the second qualifying event.

Required notices of qualifying events must be provided to the Plan Administrator in writing at the address listed in the "Plan Information" section.

How to Elect COBRA Coverage

Once notified that a qualifying event has occurred, the Plan Supervisor will notify qualified beneficiaries in writing that they have the right to elect COBRA and will send the appropriate election forms. Each qualified beneficiary will have an independent right to elect COBRA. Covered employees may elect COBRA on behalf of their spouses, and parents may elect COBRA on behalf of their children.

Qualified beneficiaries must elect COBRA within 60 days after the date coverage would otherwise end or, if later, within 60 days of the date they receive the COBRA notice from the Plan Supervisor.

Paying for COBRA Coverage

Qualified beneficiaries who elect to continue coverage under COBRA are required to pay 102% of the full cost of coverage. If COBRA continuation coverage is extended due to disability, COBRA payments will equal 150% of the full cost of coverage beginning on the 19th month of COBRA coverage.

The first payment for COBRA coverage must be made within 45 days after the date of the COBRA election and must be retroactive to the date regular coverage ended. Thereafter, COBRA payments are due on the first day of each calendar month and must be received within 30 days of the due date. If

payments are not timely received, COBRA coverage will be terminated retroactive to the last day for which payment was received.

Special COBRA Rules for TAA-Eligible Employees

The Trade Act of 2002 created a new tax credit for employees who become eligible for trade adjustment assistance (“TAA”) because their employment is adversely affected by international trade. Under these new provisions, TAA-eligible individuals can either take a tax credit or get advance payment of 65% of the premiums for COBRA coverage.

To assist TAA-eligible individuals in taking advantage of this tax credit or advance payments, the Trade Act provides them a special second COBRA election period. Therefore, if a member loses Plan coverage as a result of a TAA-related event and does not enroll in COBRA at the time, once the IRS makes a determination of TAA-eligibility, a second COBRA election period will be available to the member and covered dependents. This second election period begins on the first day of the month in which the member is determined to be TAA-eligible, provided the election is made no later than six months after the date coverage is lost as a result of the TAA-related event. COBRA coverage elected during this second election period will be effective as of the first day of the election period, not the date as of which the coverage first lapsed. The cost will be the same as described above for other COBRA coverage.

For questions about TAA eligibility, call the Department of Labor Employment and Training Administration toll-free at 1-877-US-2JOBS. For questions about the health coverage tax credit, call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282.

Termination of COBRA Coverage

COBRA continuation coverage will terminate before the end of the maximum period on the earliest of the following:

1. The date that the Employer ceases to provide a group health plan to any of its employees.
2. The date after the COBRA election date that the qualified beneficiary first becomes:
 - (a) Entitled to benefits under Medicare; or
 - (b) Covered under any other group health plan as an employee or otherwise. However, a qualified beneficiary who becomes covered under a group health plan which has a pre-existing condition exclusion will be allowed to continue COBRA coverage for the length of the pre-existing condition exclusion or to the COBRA maximum time period, if less. COBRA coverage may be terminated if the qualified beneficiary becomes covered under a group health plan with a pre-existing condition exclusion, if the pre-existing condition exclusion does not apply to or is satisfied by the qualified beneficiary by reason of the portability, access and renewal requirements of the Health Insurance Portability and Accountability Act (“HIPAA”).
3. The date the qualified beneficiary fails to pay the cost of COBRA coverage by the due date (including the applicable grace periods).
4. For a qualified beneficiary who has extended COBRA coverage of 29 months due to disability, COBRA coverage will end as of the month that begins at least 30 days after a final determination has been made by the Social Security Administration that the disabled individual is no longer disabled.

The Plan Supervisor will notify qualified beneficiaries in writing in the event COBRA coverage is terminated before the end of the applicable maximum continuation period.

Keep Plan Informed of Address Changes

In order to protect family COBRA rights, the Plan Administrator must be kept informed of any changes in the addresses of covered family members.

Questions About COBRA

For questions about COBRA continuation coverage, please contact the Plan Supervisor at 1-800-446-5439.

THIRD PARTY RECOVERY

Rights of Reimbursement and Subrogation

The Plan does not cover expenses for which another party(ies) may be responsible as a result of liability for causing or contributing to the injury or illness of you and your Dependent(s). While such expenses are not covered under this Plan, the Plan may advance payments for such expenses. As a condition to the Plan advancing payments for any condition or injury for which another party may be responsible, the covered person shall agree to reimburse the Plan in full, and in first priority, from any funds recovered from any responsible party, (which may be an individual, a company or an insurer).

The amount to be reimbursed to the Plan will equal the payments advanced by the Plan, without any adjustment for the covered person's attorney fees and costs to obtain payment from the responsible party, but will not exceed the amount received from the responsible party. The Plan's rights shall not be subject to reduction under any common fund or similar claims or theories.

The Plan shall automatically have a first priority lien upon the proceeds of any recovery from a third party as the result of a judgment, settlement, or otherwise, by or on behalf of a covered person. Such proceeds shall be deemed to be held in trust for the benefit of the Plan until reimbursement, to the extent of the payments advanced by the Plan. Any funds recovered from the third party shall be applied first to reimburse the Plan for any and all payments made under the Plan for that covered person, regardless of the following:

1. The amount of damages claimed by the covered person against the third party or whether the covered person has been made whole for such damages.
2. Any characterization of the payments by the third party with respect to the covered person's damages, such as personal injuries, future education or training or, pain and suffering.
3. The covered person recovering the funds or property being a minor.

If the covered person receives funds from the third party and does not promptly reimburse the Plan, future benefits may be reduced to cover the amount of payments advanced by the Plan.

In addition to the right to reimbursement, if the Plan advances payments for a condition or injury that another party is responsible for paying, the Plan will be subrogated to the covered person's right to recover from the third party. This means that the Plan may assume the rights of the covered person to file a lawsuit or make a claim against the party whose acts or omissions caused the condition or injury.

The Plan Administrator may in its sole and complete discretion determine whether or not to pursue the Plan's right of subrogation.

The Plan's right of full recovery may be from the third party, and liability or other insurance covering the third party, malpractice insurance; the Member's own uninsured motorist insurance, underinsured motorist insurance, any medical payment (Med-Pay), no fault, personal injury protection (PIP); or, any other first or third-party insurance coverages which are paid or payable. The Plan's right of recovery shall not be subject to reduction under any common fund or similar claim or theories.

Pursuing Reimbursement and Subrogation

These rights of reimbursement and subrogation are reserved whether the liability of a third party arises in tort, contract or otherwise. As a condition to receiving payments from the Plan, covered persons shall agree to fully assist and cooperate with the Plan Administrator in protecting and obtaining the Plan's reimbursement and subrogation rights, including, but not limited to, promptly furnishing the Plan Administrator with information concerning the person's right of recovery from any third party, and, if requested, executing and returning any reimbursement or subrogation-related documents. The covered person shall further agree not to allow the Plan's reimbursement and subrogation rights to be limited or prejudiced by any acts or omissions by the covered person. In the event of any such acts or

omissions by the covered person, the Plan Administrator shall be authorized in its sole discretion to suspend or terminate the payment or provision of any further benefits to or for the benefit of the covered person.

Please Note: If an attorney is obtained, the Plan may require him/her to complete a subrogation agreement to reimburse the Plan 100% before payments are advanced.

FILING CLAIMS

CLAIM FILING PROCEDURE

It is the responsibility of the covered person to see that doctor bills, medical bills, and hospital charges are submitted to the Plan Supervisor. Claim forms may be obtained from the Human Resources Office at your location. Claim forms must be filled out completely. Claims must be submitted to the Plan Supervisor at:

Primary PhysicianCare, Inc.
Attention: Claims Department
PO Box 11088
Charlotte, North Carolina 28220-1088
(704) 523-2758

Benefits are paid to the employee/covered person unless the provider agrees to accept the payment directly or there is a valid assignment of the right to receive payment permitted under the terms of the Plan. The following items are important and should be submitted with each claim.

1. If a provider has not completed a billing statement form, the covered person must obtain a claim form from the Human Resources Office for completion.
2. All provider bills must include the following:
 - a. Name of patient.
 - b. Date, description and charge for each service.
 - c. A complete and accurate diagnosis.
 - d. Current Procedural Terminology (CPT) code(s).
 - e. Provider's Federal ID Number or social security number.
 - f. Complete current address of physician, including zip code and telephone number.
3. Claims for medication or drug expenses must include the following:
 - a. Name of person for whom drug was prescribed.
 - b. Prescription number and name of drug.
 - c. Cost of medication and date of purchase (cash receipts, canceled checks, or credit card receipts cannot be accepted for consideration).
 - d. Name of physician prescribing drug.
 - e. For generic drugs, the prescription receipt marked GENERIC by pharmacist.
4. Copies of all other covered charges, such as for registered nurses and supply houses, must include the following:
 - a. Name of patient.
 - b. Date and charge for visit(s).
 - c. Nature of treatment or services rendered.
 - d. Federal ID Number or social security number of provider.
 - e. Complete diagnosis.

Report claims promptly. **The deadline for filing a claim for any benefit is twelve (12) months after the date that the expense is incurred. If the covered person fails to file a claim within this time period, the claimed expenses will not be covered under the Plan.**

INITIAL CLAIMS PROCESSING

Following is a description of how the Plan processes claims for benefits. A claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's procedure for making benefit claims, as described here.

There are different kinds of claims and each one has a specific timetable for approval, payment, denial, or request for further information. For questions regarding the claims procedure, please contact the Plan Supervisor.

Post-Service Claims

Post-Service Claims are those filed for payment of benefits after medical care has been received. If a Post-Service Claim is denied, the Plan Supervisor will provide written notification not later than thirty (30) days after receipt of the claim, if all needed information was provided with the claim. Sometimes additional time is necessary to process a claim due to circumstances beyond the control of the Plan. If an extension is necessary, the Plan Supervisor will provide written notification within the thirty (30) day period of the reasons for the extension and the date by which it expects to render a decision. The extension generally will be no longer than fifteen (15) days, unless additional information is needed.

If the extension is necessary because additional information is needed, the notice of extension will describe the additional information required. The additional information must be provided within forty-five days. If all the needed information is received within that time limit and the claim is denied, the Plan Supervisor will provide notification the denial within fifteen (15) days after the information is received. If the needed information is not received within the forty-five (45) day period, the Plan Supervisor may decide the claim without that information.

A notification of denial will include:

1. The specific reason(s) for the denial.
2. Reference to the specific Plan provisions on which the determination is based.
3. A description of any additional material or information necessary to perfect the Claim and an explanation of why such material or information is necessary.
4. A description of the Plan's appeal procedures and of your right to bring a civil action under federal law following the denial of an appeal.
5. A statement disclosing any internal rule, guideline, protocol, or similar criterion referenced in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request).
6. If the denial is based on a medical necessity or experimental treatment or similar exclusion, an explanation of the scientific or clinical judgment for the adverse benefits determination (or a statement that such explanation will be provided free of charge upon request).

Pre-Service Claims

Pre-Service Claims are those claims that require notification or approval prior to receiving medical care (for example, non emergency hospitalizations and surgery). If a Pre-Service Claim is submitted properly with all needed information, the Plan Supervisor will send notification of the benefit determination, whether adverse or not, no later than fifteen (15) days from receipt of the claim.

If a Pre-Service Claim is not filed in accordance with the Plan's procedures, the Plan Supervisor will send notification of the improper filing, and how to correct it, within five (5) days after the improper claim is received.

If an extension is necessary to process your Pre-Service Claim, the Plan Supervisor will send written notification within the initial fifteen (15) day response period, and may request a one-time extension of up to fifteen (15) days. If the extension is necessary because additional information is needed, the notice of extension will describe the additional information required. The additional information must be provided within forty-five (45) days. If all the needed information is received within that time

limit, the Plan Supervisor will provide written notification of the determination within fifteen (15) days after the information is received. If the needed information is not provided within the forty-five (45) day period, the Plan Supervisor may decide the claim without that information.

A denial notification will include the information listed here for Post-Service Claim details.

Urgent Care Claims

Urgent Care Claims are those that require pre-certification prior to receiving medical care, and where a delay:

1. Could seriously jeopardize life or health or the ability to regain maximum function.
2. In the opinion of a physician with knowledge of the member's medical condition, could cause severe pain.

If an Urgent Care Claim is filed in accordance with the Plan's procedures and include all needed information, the Plan Supervisor will provide notice of the determination, whether adverse or not, as soon as possible, but no later than seventy-two (72) hours after receipt of the Urgent Care Claim. However, the Plan's procedures are not followed; the Plan Supervisor will provide notice of the improper filing and how to correct it within twenty-four (24) hours of receipt of the improper claim. This notification may be oral, unless the member requests a written notification.

If all the information required to decide your claim is not provided, the Plan Supervisor will provide notice of the additional information needed within twenty-four (24) hours after receipt of the claim. The requested information must be provided within forty-eight (48) hours. The Plan Supervisor will provide notice of the determination on the claim no more than forty-eight (48) hours after the earlier of the following:

1. The Plan Supervisor's receipt of the requested information.
2. The end of the forty-eight (48) hours given to you to provide the requested information.

A denial of an Urgent Care Claim will include the information listed here for Post-Service Claim denials. Notifications regarding Urgent Care Claim determinations may be oral, with written or electronic confirmation to follow within three (3) days.

Concurrent Care Claims

There are two types of Concurrent Care Claims:

1. A claim to extend coverage for a course of treatment beyond a previously approved period of time or number of treatments.
2. A claim regarding reduction or termination of coverage by the Plan before the end of a previously approved period of time or number of treatments.

A request to extend an ongoing course of treatment must be submitted at least twenty-four (24) hours before the end of the previously approved limit. If a request for extension is made timely and involves Urgent Care, the Plan Supervisor will provide notification of the determination, whether adverse or not, within twenty-four (24) hours after the claim is received. If the claim is not made at least twenty-four (24) hours prior to the end of the previously approved limit, the request will be treated as an Urgent Care Claim (not a Concurrent Care Claim) and decided according to the timeframes described here for Urgent Care Claims. A request to extend coverage that does not involve urgent care will be considered a new claim and will be decided according to the Post-Service or Pre-Service timeframes described here, as applicable.

If an ongoing course of treatment previously approved by the Plan is denied for continued coverage, the Plan Supervisor will provide notice sufficiently in advance to allow for an appeal.

Notices regarding denials of Concurrent Care Claims will include the information listed for Post-Service Claim denials.

Questions About Claim Determinations

Questions or concerns about a determination on your claim, contact the Plan Supervisor to inquire about it. This often clears up questions about benefit determinations, what the Plan covers, or what services were actually provided. The Plan Supervisor can be reached by calling the telephone number on the ID card or by writing to the address indicated above. A representative of the Plan Supervisor's Claims Department will be available to answer questions about the claim. If the Plan Supervisor cannot resolve the issue satisfactorily, a formal appeal may be made as described below. Remember that a member is not required to contact the Plan Supervisor informally. If the member is not satisfied with a benefit determination, it may be appealed immediately.

APPEALS

This Plan offers a two-level appeals procedure.

NOTE: To appeal an Urgent Care Claim denial, please refer to the Urgent Care Appeals section below and call the Plan Supervisor immediately at the number indicated on the ID card.

How to File a Level One Appeal

A level one appeal is made to the Plan Supervisor in order to verify that the claim was processed properly and free of mechanical or factual error. Except for appeals involving Urgent Care (See Urgent Care Appeals), to appeal the initial denial of a claim, a request for appeal must be submitted in writing to the Plan Supervisor at the address indicated below:

Primary PhysicianCare, Inc.
Post Office Box 11088
Charlotte, NC 28220

A level one appeal must be filed within one hundred eighty (180) days of receipt of the notice of denial. Comments, documents, and other information may be submitted in support of the claim. The review on appeal will consider any information submitted, even if it was not submitted for or considered as part of the initial determination. Also, upon request and free of charge, reasonable access to and copies of all documents, records, and information that are relevant to your claim will be provided.

A document, record, or other information shall be considered relevant to a claim if it:

1. Was relied upon in making the benefit determination.
2. Was submitted, considered, or generated in the course of making the benefit determination.
3. Demonstrates compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants.
4. Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

Determinations on a Level One Appeal

The review on appeal will afford no deference to the initial benefit determination. Someone other than the individual involved in the initial benefit determination, not a subordinate of that individual, will be appointed to decide the appeal.

If the claim was denied based on a medical judgment (such as whether a service or supply is Medically Necessary, Experimental or Investigational), the Plan Supervisor will consult with a health professional with appropriate training and experience. The health care professional consulted for the appeal will not be a professional (if any) consulted during the initial determination or a subordinate of that professional. The Plan Supervisor also will identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, even if the advice was not relied upon in making the benefit determination.

The Plan Supervisor will provide written or electronic notification of the determination on appeal as follows:

1. For level one appeals of Pre-Service Claims, not later than fifteen (15) days after receipt of the appeal.
2. For level one appeals of Post-Service Claims, not later than thirty (30) days after receipt of the appeal.

If the appeal is denied, the notification will include:

1. The specific reason(s) for the denial.

2. Reference to the specific Plan provisions on which the determination is based.
3. A statement that the member entitled to receive, upon request and free of charge, reasonable access to or copies of all documents, records, or other information relevant to the claim.
4. A statement of the appeals procedures offered by the Plan and a statement of the right to bring civil action under Federal law.
5. A statement disclosing any internal rule, guideline, protocol, or similar criterion referenced in making the adverse determination (or a statement that such information will be provided free of charge upon request).
6. If the denial on appeal is based on a medical necessity or experimental treatment or similar exclusion, an explanation of the scientific or clinical judgment for the adverse benefits determination (or a statement that such explanation will be provided free of charge).

How to File a Level Two Appeal

Except for appeals involving Urgent Care (See Urgent Care Appeals), a level two appeal must be submitted in writing to the Plan Administrator at the address indicated below:

c/o Primary PhysicianCare, Inc.
Post Office Box 11088
Charlotte, NC 28220

A level two appeal must be filed within ninety (90) days of the receipt of the level one appeal denial. Comments, documents, and other information may be submitted in support of the claim. The review of the level two appeal will consider any information submitted, even if it was not submitted for or considered as part of the initial determination or level one appeal. Also, upon request and free of charge, reasonable access to and copies of all documents, records, and information that are relevant to the claim and level one appeal will be provided.

A document, record, or other information shall be considered relevant to a claim if it:

1. Was relied upon in making the benefit determination.
2. Was submitted, considered, or generated in the course of making the benefit determination.
3. Demonstrates compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants.
4. Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

Determinations on a Level Two Appeal

The review on the level two appeal will be made by the Plan Administrator, and will afford no deference to the initial benefit determination and level one appeal. Someone other than the individual involved in the initial benefit determination and level one appeal, not a subordinate of either individual, will be appointed by the Plan Administrator to decide the appeal.

If the claim and appeal was denied based on a medical judgment (such as whether a service or supply is Medically Necessary, Experimental or Investigational), the Plan Administrator will consult with a health professional with appropriate training and experience. The health care professional consulted for the appeal will not be a professional (if any) consulted during the initial determination and the level one appeal or a subordinate of that professional. The Plan Administrator also will identify any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, even if the advice was not relied upon in making the benefit determination.

The Plan Administrator will provide written or electronic notification of the determination on appeal as follows:

1. For level two appeals of Pre-Service Claims, not later than fifteen (15) days after receipt of the appeal.
2. For level two appeals of Post-Service Claims, not later than thirty (30) days after receipt of the appeal.

If the level two appeal is denied, the notification will include:

1. The specific reason(s) for the denial.
2. Reference to the specific Plan provisions on which the determination is based.
3. A statement that the member is entitled to receive, upon request and free of charge, reasonable access to or copies of all documents, records, or other information relevant to the claim.
4. A description of any voluntary appeal procedures offered by the Plan and a statement of the right to bring civil action under Federal law.
5. A statement disclosing any internal rule, guideline, protocol, or similar criterion referenced in making the adverse determination (or a statement that such information will be provided free of charge upon request).
6. If the denial on appeal is based on a medical necessity or experimental treatment or similar exclusion, an explanation of the scientific or clinical judgment for the adverse benefits determination (or a statement that such explanation will be provided free of charge).

Urgent Care Appeals

An appeal involves Urgent Care and requires immediate action if a delay could significantly increase the risk to the member's health or impair the ability to regain maximum function or, in the opinion of a physician with knowledge of the member's condition, could cause severe pain.

If an appeal involves Urgent Care, the appeal does not need to be submitted in writing. The member or physician should call the Plan Supervisor immediately at the number indicated on the ID card. The Plan Supervisor will provide notice of the determination on the appeal as soon as possible, but not later seventy-two (72) hours after receipt of the appeal. The notification may be written or electronic and will include the information described here for other appeal denials.

Voluntary Level of Appeal

The Plan offers a voluntary level of appeal that may include mediation or arbitration. Claimants may submit a benefit dispute to this voluntary appeal only after exhaustion of the appeals process described in the Appeals section.

If the claimant elects the voluntary level of appeal, any statute of limitations or other defense based on timeliness will be tolled during the time the voluntary appeal is pending. In addition, the Plan shall not assert that a claimant has failed to exhaust administrative remedies by not electing to submit the benefit dispute to the voluntary appeal provided by the Plan.

The Plan will provide to the claimant, upon request and at no cost, sufficient information about the voluntary appeal process to enable the claimant to make an informed judgment on whether or not to submit a benefit dispute to the voluntary level of appeal. This information will include a statement that the decision will have no effect on the claimant's rights to any other benefits under the Plan, will list the rules of the appeal, will state the claimant's right to representation, will enumerate the process for selecting the decision maker, and will give circumstances, if any, that may affect the impartiality of the decision maker.

No fees or costs will be imposed on the claimant as part of the voluntary level of appeal, and the claimant will be so informed.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

Plan Administrator. The Plan Sponsor may appoint an individual or a committee to serve as Plan Administrator of the Plan. If the Plan Administrator resigns, dies, or is otherwise removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

If the Plan Sponsor does not otherwise appoint a Plan Administrator, the Plan Sponsor shall be the Plan Administrator.

The Plan Administrator is required to administer this Plan in accordance with its terms and has the authority to establish policies and procedures for the management and operation of the Plan. It is the express intent of this Plan that the Plan Administrator shall have sole and complete discretionary authority to construe and interpret the terms and provisions of the Plan, to decide issues regarding eligibility and benefits due under the Plan, and to make all determinations, including factual determinations, arising under the Plan. Except as otherwise required by law, the decisions of the Plan Administrator will be final and binding for all interested parties.

Duties of the Plan Administrator. The Plan Administrator's duties include:

1. To administer the Plan in accordance with its terms.
2. To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions.
3. To settle disputes which may arise relative to a participant's or beneficiary's rights.
4. To prescribe procedures for filing claims for benefits and to review claim denials.
5. To keep and maintain the Plan documents and all other records pertaining to the Plan.
6. To appoint a claims administrator to process and pay claims.
7. To perform all necessary reporting as required by ERISA.
8. To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Section 609.
9. To delegate to any person or entity such powers, duties, and responsibilities, as it deems appropriate.

Plan Administrator Compensation. The Plan Administrator serves without compensation from the Plan Sponsor. However, all administrative expenses of the Plan, including compensation for services contracted from third parties in connection with the Plan, will be paid by the Plan Sponsor.

Fiduciary. A fiduciary is anyone who (i) exercises discretionary authority or control over the management of the Plan or the management and disposition of Plan assets; (ii) renders investment advice to the Plan; or (iii) has discretionary authority or responsibility in the administration of the Plan.

Fiduciary Duties. A fiduciary must carry out his or her duties and responsibilities solely in the interest of participants and beneficiaries as follows:

1. For the exclusive purpose of providing benefits to employees and their dependents and defraying reasonable expenses of administering the Plan.
2. With the care, skill, prudence, and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation.
3. In accordance with the Plan documents to the extent that they are consistent with ERISA.

The Named Fiduciary. A "named fiduciary" is the Plan Administrator. The named fiduciary can appoint others to carry out fiduciary responsibilities other than as Plan trustees. These other persons become fiduciaries themselves and have fiduciary responsibility for their acts under the Plan. To the

extent that the named fiduciary allocates fiduciary responsibilities to other persons, the named fiduciary shall not be liable for any act or omission of those persons unless:

1. The appointment was imprudent or the named fiduciary fails to monitor the conduct and performance of the appointee; or
2. The named fiduciary breached his or her fiduciary responsibility under Section 405(a) of ERISA.

Plan Supervisor Is Not a Fiduciary. The Plan Supervisor is not a fiduciary under the Plan by virtue of processing and paying claims in accordance with the Plan's rules as established and interpreted by the Plan Administrator.

A participant or beneficiary shall not rely on any oral statement from any employee or customer representative of the Plan Supervisor to:

1. Modify or otherwise amend the benefits, limitations and exclusions or other provisions of this Plan.
2. Increase, reduce, waive or void any coverage or benefits under this Plan.

Any statement by the Plan Supervisor should not be interpreted as a guarantee of coverage or payment for any services rendered or otherwise provided to a participant or beneficiary.

GENERAL INFORMATION

PLAN AMENDMENTS AND TERMINATION

The Plan Sponsor reserves the right to modify, amend or terminate the Plan completely or in part. The Plan may be amended or terminated by formal action of the board of directors of the Plan Sponsor or by appropriate action of any person(s) authorized to act on behalf of the board of directors of the Plan Sponsor.

If the Plan, or any benefit offered under the Plan, is amended, modified or terminated, the rights of covered persons are limited to covered charges incurred before the effective date of that amendment, modification or termination. Covered persons will be informed of any changes that affect their coverage.

ASSIGNMENTS

Benefits under the Plan may not be voluntarily or involuntarily assigned or alienated, provided, that payment of benefits of a covered person will be made directly to a physician, hospital or other provider furnishing services to the extent that the covered person has authorized such physician, hospital or other provider to receive direct payment of benefits due under the Plan. Assignment of benefits for any purpose other than direct payment to providers shall not be permitted and shall not be binding on the Plan, the Plan Administrator or the Employer.

CLERICAL ERROR & MISSTATEMENTS

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered. If any relevant information as to the amount of coverage shall have been misstated, the facts will determine whether or not, and how much, coverage is in force.

OVER PAYMENTS

If a member or any other person or entity receives a benefit payment that exceeds the amount of benefits payable under the Plan, the Plan has the right to either (i) require that the member or the person or entity that was paid return the amount of the overpayment or (ii) reduce any future benefit payments to the member or his/her dependents by the amount of the overpayment. This right does not affect any other right of recovery concerning the overpayment.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not a contract of employment, and participation in the Plan does not guarantee any person's employment with the Employer.

PRIOR COVERAGE PROVISION

This provision applies only to a person who was covered on the date this Plan first became effective and who was covered under the prior plan, which this Plan replaced.

1. **Pre-existing Conditions.** Benefits for pre-existing conditions will be equal to the lesser of:
 - a. benefits payable under the prior plan had it remained in effect; or
 - b. benefits payable under this Plan.

If any person is eligible for continuation of coverage under the prior plan, benefits under this Plan will be limited to only those eligible expenses not eligible for payment under continuation of coverage under the prior plan.

2. **Deductible.** This Plan will allow credit toward the deductible for any portion of the calendar year deductible that the covered person satisfied under the prior plan.

PRIVACY RIGHTS UNDER HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that the Plan protect the confidentiality of your private health information. A description of your privacy rights under HIPAA can be found in the Plan's Notice of Privacy Practices provided upon enrollment.

Uses and Disclosures of Protected Health Information (PHI)

This Plan will not use or disclose your individually identifiable health information protected by HIPAA ("protected health information") except as necessary for treatment, payment, and other health care operations, or as permitted or required by law. The Plan also requires all of its business associates (as that term is defined by HIPAA) to observe HIPAA's privacy requirements.

The Plan also may use or disclose protected health information about individuals covered under the Plan in communications with family members involved in the care or payment of health care of that individual, if relevant to such involvement. In addition, the Plan may disclose protected health information if required by law or for certain public health and national priority purposes, including: (1) as authorized and necessary to comply with workers' compensation laws, (2) in response to a subpoena or other valid legal process, (3) to health oversight agencies and public health authorities, and (4) to authorized government officials for intelligence and national security activities authorized by law.

Disclosure Protected Health Information ("PHI") to Plan Sponsor

The Plan will disclose (or require the Plan Supervisor to disclose) PHI to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions for the Plan not inconsistent with the requirements of HIPAA. Any disclosure to and use by the Plan sponsor will be subject to and consistent with the restrictions set forth below:

Restrictions on Plan Sponsor's Use and Disclosure of ("PHI")

1. The plan sponsor will neither use nor further disclose Member's PHI, except as permitted or required by the Plan Documents, as amended or required by law.
2. The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides Member PHI agrees to the restrictions and conditions of the Plan, with respect to Member's PHI.
3. The Plan sponsor will not use or disclose Member PHI for employment-related actions or decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor.
4. The Plan Sponsor will report to the Plan any use or disclosure of Member PHI that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.
5. The Plan Sponsor will make PHI available to the Member who is the subject of the information in accordance with HIPAA.
6. The Plan Sponsor will make Member PHI available for amendment, and will on notice amend Member PHI, in accordance with HIPAA.
7. The Plan Sponsor will track disclosures it may make of Member PHI so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with HIPAA.
8. The Plan Sponsor will make its internal practices, books, and records, relating to its use and disclosure of Member PHI, to the Plan and to the U.S. Department of Health and Human Services to determine compliance with HIPAA.
9. The Plan Sponsor will, if feasible, return or destroy all Member PHI, in whatever form or medium (including in any electronic medium under the Plan Sponsor's custody or control), received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any Member who is the subject of the PHI, when the Member's PHI is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Member PHI, the Plan Sponsor will limit the use or disclosure of

any Member PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

10. The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan.
11. The Plan Sponsor will ensure that any agent, including a subcontractor, to whom Plan Sponsor provides electronic PHI (that Plan Sponsor creates, receives, maintains or transmits on behalf of the Plan), agrees to implement reasonable and appropriate security measures to protect this information.
12. The Plan Sponsor shall report any security incident of which it becomes aware to the Plan as provided below:
 - a. In determining how and how often the Plan Sponsor shall report security incidents to the Plan, both Plan Sponsor and Plan agree that unsuccessful attempts at unauthorized access or system interference occur frequently and that there is no significant benefit for data security from requiring the documentation and reporting of such unsuccessful intrusion attempts. In addition, both parties agree that the cost of documenting and reporting such unsuccessful attempts as they occur outweigh any potential benefit gained from reporting them. Consequently, both Plan Sponsor and Plan agree that this Agreement shall constitute the documentation, notice and written report of any such unsuccessful attempts at unauthorized access or system interference as required above and by 45 CFR Part 164, Subpart C and that no further notice or report of such attempts will be required.
 - b. Plan Sponsor shall, however, separately report to the Plan (i) any successful unauthorized access, use, disclosure, modification or destruction of the Plan's electronic PHI of which Plan Sponsor becomes aware if such security incident either results in a breach of confidentiality, results in a breach of integrity but only if such breach results in a significant, unauthorized alteration or destruction of the Plan's electronic PHI, or results in a breach of availability of the Plan's electronic PHI, but only if said breach results in a significant interruption to normal business operations. Such reports will be provided in writing within ten (10) business days after Plan Sponsor becomes aware of the impact of such security incident upon the Plan's electronic PHI.
13. Adequate separation between the Plan Sponsor and the Plan will be achieved by giving access to Member PHI to certain classes of employees under the control of the Plan Sponsor. Protected health information may be disclosed to and used by human resources, benefits, finance/accounting and information technology employees of the Employer who are responsible for carrying out administrative functions for the Plan – for example, benefit determinations, benefit payments, and claims audits. However, these employees will only have access to the information on a “need to know” basis and will use and disclose only the minimum necessary protected health information to accomplish the intended Plan administration purpose. Plan Sponsor has implemented procedures for handling non-compliance.

YOUR RIGHTS UNDER ERISA

Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan participants shall be entitled to the following:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office, all documents governing the Plan, including insurance contracts, and a copy of the latest Annual Report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts, and copies of the latest Annual Report (form 5500 series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's Annual Financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Plan Coverage

- Continue health care coverage for yourself, your spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents will have to pay for such coverage.
- Receive a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under this Plan if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from the Plan when coverage is lost under the Plan, when you become entitled to elect COBRA continuation of coverage, when COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to twenty-four (24) months after losing coverage. Without evidence of creditable coverage, a Plan participant may be subject to pre-existing condition exclusion for twelve (12) months, or eighteen (18) months for late enrollees, after your enrollment date in the Plan.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan participants and their beneficiaries. No one, including the Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining benefits under the Plan or from exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps that you can take to enforce your rights. For instance, if you request a copy of the Plan Document or the latest Annual Report from the Plan and do not receive them within 30 days, you may sue in federal court. In that event, the court may require the Plan Administrator to provide the materials and to pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have

a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court.

In the event that the Plan fiduciaries misuse the Plan's money, or if a plan participant is discriminated against for asserting his or her rights, he or she may seek assistance from U.S. Department of Labor or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the plan participant is successful, the court may order the person sued to pay the costs and fees. If the plan participant loses the suit, the court may order him or her to pay the costs and fees (for example, if the court finds the claim or suit to be frivolous).

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact either the nearest area office of the Pension and Welfare Benefits Administration of the U.S. Department of Labor listed in the telephone directory or the Division of Technical Assistance and Inquiries of the Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.



VSP Exam Plus Plan

The Exam Plus Plan is a basic plan with a covered in full eye exam and discounts for eyewear through a VSP Preferred Provider.¹

Plan Coverage			
WellVision Exam [®]	<ul style="list-style-type: none"> • Thorough eye exam covered in full² 		
Glasses	<ul style="list-style-type: none"> • 20% off complete pairs of prescription glasses • 20% off all lens options • 20% off unlimited non-prescription sunglasses³ 		
Contact Lenses	<ul style="list-style-type: none"> • 15% off contact lens services, excluding materials 		
Value-added Benefits			
Laser VisionCare Program	<ul style="list-style-type: none"> • VSP-contracted laser centers provide discounts for laser surgery including PRK, LASIK, and Custom LASIK⁵ • Discounts average 15% off or 5% off if the laser center is offering a promotional price⁶ 		
Exclusions			
Plan Limitations	<table border="0"> <tr> <td style="vertical-align: top;"> <p>The following items are excluded under this plan:</p> <ul style="list-style-type: none"> • Two pairs of glasses instead of bifocals • Replacement of lenses, frames or contacts • Medical or surgical treatment • Orthoptics, vision training or supplemental testing </td> <td style="vertical-align: top; padding-left: 20px;"> <p>Items not covered under the contact lens coverage:</p> <ul style="list-style-type: none"> • Insurance policies or service agreements • Artistically painted or non-prescription lenses • Additional office visits for contact lens pathology • Contact lens modification, polishing or cleaning </td> </tr> </table>	<p>The following items are excluded under this plan:</p> <ul style="list-style-type: none"> • Two pairs of glasses instead of bifocals • Replacement of lenses, frames or contacts • Medical or surgical treatment • Orthoptics, vision training or supplemental testing 	<p>Items not covered under the contact lens coverage:</p> <ul style="list-style-type: none"> • Insurance policies or service agreements • Artistically painted or non-prescription lenses • Additional office visits for contact lens pathology • Contact lens modification, polishing or cleaning
<p>The following items are excluded under this plan:</p> <ul style="list-style-type: none"> • Two pairs of glasses instead of bifocals • Replacement of lenses, frames or contacts • Medical or surgical treatment • Orthoptics, vision training or supplemental testing 	<p>Items not covered under the contact lens coverage:</p> <ul style="list-style-type: none"> • Insurance policies or service agreements • Artistically painted or non-prescription lenses • Additional office visits for contact lens pathology • Contact lens modification, polishing or cleaning 		

¹ Plan available through various provider networks including the VSP Network, Choice Network, Select Network, and Advantage Network.

² Less any applicable copay.

³ Discounts valid through any VSP Preferred Provider within 12 months of the last covered eye exam.

⁴ If a member selects a lens from a tier that is above their allowance they pay the difference. If a member selects a lens from a tier that is below their allowance they may apply the remaining balance toward additional contact lenses. This program was designed for standard fit members, VSP Preferred Providers will determine if a member qualifies.

⁵ Custom LASIK coverage only available using wavefront technology with the microkeratome surgical device. Other LASIK procedures may be performed at an additional cost to the member.

⁶ LaserVision Care discounts are only available from VSP-contracted facilities.



Your VSP Vision Benefits Summary

Why enroll in a VSP® Vision Care plan? We'll help keep you and your eyes healthy. Plus, you'll get a great value on your eyecare and eyewear.

You'll like what you see with VSP.

Value and Savings. You'll get great benefits on your exam and eyewear at an affordable price.

Personalized Care. You'll get quality care that focuses on your eyes and overall wellness with a WellVision Exam® from a VSP doctor. They'll look for vision problems and signs of other health conditions.

When you see a VSP doctor, you'll get the most out of your benefit and have lower out-of-pocket costs. Plus, you'll be 100% happy with your eyecare and eyewear from a VSP doctor or we'll make it right.

Eyewear. Choose the eyewear that's right for you and your budget. From classic styles to the latest designer fashions, you'll find hundreds of options for you and your family.

Choice of Providers. With open access to see any eyecare provider, you can see the one who's right for you. Choose a VSP doctor or any other provider. To find a VSP doctor, visit vsp.com or call **800.877.7195**.

Enroll today. You'll be glad you did.

Once your plan is effective, register on vsp.com to view a complete description of your benefits. To use your vision coverage, simply tell your eyecare provider that you have VSP. No ID card is necessary.

Contact us. vsp.com | **800.877.7195**

Buy-Up Plan

Averett University Employee Health Plan and VSP provide you with an affordable eyecare plan. Sign up for VSP today.

Doctor Network.....VSP Signature

Your Coverage with a VSP Doctor

WellVision Exam® focuses on your eye health and overall wellness

- \$15.00 copayevery 12 months

Prescription Glasses

- \$25.00 copay

Lensesevery 24 months

- Single vision, lined bifocal, and lined trifocal lenses.
- Polycarbonate lenses for dependent children.

Frameevery 24 months

- \$130.00 allowance for a wide selection of frames
- 20% off the amount over your allowance.

~OR~

Contact Lens Care

- No copayevery 12 months

\$130.00 allowance for contacts and the contact lens exam (fitting and evaluation).

Current soft contact lens wearers may qualify for a special program that includes a contact lens exam and initial supply of lenses.

Extra Discounts and Savings

Glasses and Sunglasses

- Average 35 - 40% savings on all non-covered lens options
- 30% off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam. Or get 20% off from any VSP doctor within 12 months of your last WellVision Exam

Contacts

- 15% off cost of contact lens exam (fitting and evaluation)

Laser Vision Correction

- Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.
- After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor

Your Coverage with Other Providers

Visit vsp.com for details, if you plan to see a provider other than a VSP doctor.

Exam.....	Up to \$46.00
Single vision lenses	Up to \$55.00
Lined bifocal lenses	Up to \$75.00
Lined trifocal lenses	Up to \$95.00
Frame	Up to \$50.00
Contacts.....	Up to \$105.00

VSP guarantees service from VSP doctors only. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.





**RIDER TO THE SUMMARY PLAN DESCRIPTION
AND MASTER PLAN DOCUMENT FOR
AVERETT UNIVERSITY**

Rider: Dependents up to age 26: Averett University employees hired or enrolled prior to January 1, 2011.

Effective Date: January 1, 2011

Dependent Coverage

Employees hired prior to January 1, 2011 will not be required to verify dependent employee insurance coverage.

This rider will not alter or affect any of the terms of the Plan other than as stated above and is accepted as stated above.

A

abortion	11, 17
acupuncture	17
ambulance	11, 19
ambulatory surgery center.....	11
anesthesia	11
assistant surgeon	11

C

case management	19, 40
circumcision	11, 14
COBRA.....	24, 25, 28, 29, 30, 44, 46, 48
cosmetic surgery	31
custodial care	11, 12, 17, 31, 33

D

dangerous leisure activities	17
dental care	11
diabetic supplies.....	11
durable medical equipment	11

E

exercise programs	18
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F

full-time student	32
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H

hearing aids	18
home health.....	11, 13
hospice	14, 33
hospice care.....	11
hypnosis	17

I

infertility	18
intensive care	11
investigational	32

M

marital counseling.....	18
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mental health

behavioral disorders	17
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O

obesity	18
organ transplant.....	12, 40
orthodontics	13, 19
oxygen	12

P

pain therapy	12
plan administrator.....	60
pre-certification	19, 38, 39
pre-existing conditions	18, 48, 60
pregnancy	11, 12, 17, 18, 21, 33
prescription drugs	12, 14

R

rehabilitative care	12
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S

self-inflicted injury	17
skeletal adjustment	15, 36
sleep disorder.....	36
sterilization	12, 18

T

termination of coverage.....	19
therapy	
occupational therapy	12, 15
physical therapy	12
speech therapy.....	12, 13, 35

V

vertebral manipulation.....	12, 15, 36
vision care	19

W

weight reduction.....	<i>see obesity</i>
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